

Date \_\_\_\_\_

# Confidential Responsible Party Information

A B C

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  Own  Rent  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Confidential Patient Information

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Email \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Insurance Information

Policy Holder's Name \_\_\_\_\_ Member ID# or Soc.Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Do you have dual coverage? No  Yes  If yes:

Policy Holder's Name \_\_\_\_\_ and Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand all procedures in this office may be audio-visually recorded for security and training purposes.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

welcome

\_\_\_\_\_

PATIENT NUMBER

Patient's Name \_\_\_\_\_

Last

First

Initial

Nickname

Date of Birth

Parent's Guardian's Name \_\_\_\_\_

**DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER**

1. Is this your child's first visit to a dentist? . . . . .YES NO
2. If not, how long since the last visit to the dentist? \_\_\_\_\_
3. Were any x-rays or radiographs taken when your child previously visited the dentist? . . .YES NO
4. Does your child eat between meals? . . . . .YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? . . . . .YES NO
6. When does your child brush his/her teeth?  
 Upon arising     After eating any food     Right after meals     Before going to bed
7. How does your child receive Fluoride?  
 Community water level \_\_\_\_ ppm     Well water level \_\_\_\_ ppm  
 Fluoride drops or tablets     Fluoride rinse or gel
8. Have any cavities been noted in the past? . . . . .YES NO
9. Were any teeth (baby or permanent) removed by extraction? . . . . .YES NO  
Was it suggested that the space be maintained . . . . .YES NO  
Was an appliance placed . . . . .YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? . . . . .YES NO  
If so describe \_\_\_\_\_
11. Has your child had any problem with dental treatment in the past? . . . . .YES NO
12. Has anyone in the family, including parents, had orthodontics? . . . . .YES NO
13. Has your child ever received a local anesthetic? . . . . .YES NO
14. Has your child ever had occlusal sealants? . . . . .YES NO
15. Does your child think there is anything wrong with his/her teeth? . . . . .YES NO

**MEDICAL HISTORY**

1. Does your child have a health problem? . . . . .YES NO
2. Is your child under care of physician? . . . . .YES NO  
If yes, since when and why? \_\_\_\_\_  
Phone \_\_\_\_\_
3. Name of physician \_\_\_\_\_
4. Is your child receiving any medication? . . . . .YES NO  
What? \_\_\_\_\_
5. Is your child allergic to penicillin, antibiotics or other drugs? . . . . .YES NO
6. Is your child allergic to or sensitive to any metals or latex? . . . . .YES NO
7. Does your child have other allergies? . . . . .YES NO
8. Has your child had any serious illness? . . . . .YES NO  
When \_\_\_\_\_ What \_\_\_\_\_
9. Has your child ever had surgery? . . . . .YES NO
10. Does your child have a heart murmur? . . . . .YES NO
11. Is surgery contemplated? . . . . .YES NO
12. Does your child experience severe or prolonged bleeding? . . . . .YES NO
13. Does your child have AIDS or has he/she tested HIV positive? . . . . .YES NO
14. Has your child tested positive for hepatitis? . . . . .YES NO
15. Is your child subject to nervous disorders? . . . . .YES NO  
 Fainting?     Seizures?     Dizziness?     Behavioral/Learning problems?
16. Does your child have frequent headaches? . . . . .YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

**COMMENTS**

\_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

MED. ALERT

**CHILD DENTAL MEDICAL HISTORY**