Patient Information

Patient Name: ____
Last | First | MI | (Preferred Name)

Date of Birth: ___/___/___ **SSN#:** ____________ **Gender:** ☐ Male ☐ Female

Address: ____
Street | Apt #

____
City | State | Zip Code

Health Information

Date of Last Dental Exam: ____________ **X-rays taken?** Y N **Reason for this Visit:** ____________

Has your child ever had any of the following? Please circle Yes or No.

Condition		Condition		Condition		Condition	
ADD/ADHD	Y N	Dizziness	Y N	Herpes	Y N	Respiratory Problems	Y N
AIDS/HIV Positive	Y N	Down Syndrome	Y N	High Blood Pressure	Y N	Rheumatic Fever	Y N
Allergies (Seasonal)	Y N	Drug Addiction	Y N	Hypoglycemia	Y N	Rheumatism	Y N
Anxiety/Panic	Y N	Epilepsy or Seizures	Y N	Jaundice	Y N	Sinus Problems	Y N
Asthma	Y N	Excessive Bleeding	Y N	Irregular Heartbeat	Y N	Spina Bifida	Y N
Autism	Y N	Fainting Spells	Y N	Kidney Problems	Y N	Stomach Problems	Y N
Blood Disease	Y N	Frequent Cough	Y N	Leukemia	Y N	Stroke	Y N
Cancer	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Thyroid Disease	Y N
Chemotherapy	Y N	Glaucoma	Y N	Low Blood Pressure	Y N	Tuberculosis	Y N
Cold Sores/Fever Blisters	Y N	Head Injuries	Y N	Mental Disorders	Y N	Tumors or Growths	Y N
Congenital Heart Disorder	Y N	Heart Disease	Y N	Nervous Disorders	Y N	Ulcers	Y N
Convulsions	Y N	Heart Murmur	Y N	Pain in Jaw Joints	Y N	Venereal Disease	Y N
Developmentally Delayed	Y N	Hepatitis A	Y N	Pregnancy	Y N	Yellow Jaundice	Y N
Diabetes	Y N	Hepatitis B or C	Y N	Radiation Treatment	Y N	Other	Y N

Please list any serious illness not listed above: ______________________

Does your child have any drug allergies? ☐ Yes ☐ No | If yes, please explain: ______________________

List any medication(s) your child is currently taking: ______________________

Has he/she ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ______________________

Does he/she have any of the following habits?

☐ Lip Sucking/Biting ☐ Nail Biting ☐ Nursing/Bottle Habits ☐ Thumb/Finger Sucking

Has he/she been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: ______________________

Are there any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: ______________________

Name of Physician: ______________________ **Phone number:** ______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are ever changes in my child's health, I will inform the doctors at the next appointment without fail.

____
Signature of Parent or Guardian **Date**

Responsible Party Information

The following is for: ☐ the patient's parent(s) or legal guardian ☐ the person responsible for payment

Name: ______________________ **Marital Status:** ☐ married ☐ single ☐ divorced **Date of Birth:** ____/____/____

Relationship to Patient: ☐ Mother ☐ Father ☐ Other: ______________________ **SSN#:** ______________

Phone (Home): ______________ **(Cell):** ______________ **Email:** ______________________

Address: ____

Street **Apt #**

____

City **State** **Zip Code**

The following is for: ☐ the patient's parent(s) or legal guardian ☐ the person responsible for payment

Name: ______________________ **Marital Status:** ☐ married ☐ single ☐ divorced **Date of Birth:** ____/____/____

Relationship to Patient: ☐ Mother ☐ Father ☐ Other: ______________________ **SSN#:** ______________

Phone (Home): ______________ **(Cell):** ______________ **Email:** ______________________

Address: ____

Street **Apt #**

____

City **State** **Zip Code**

Insurance Information

PRIMARY

Policy Holder: ____ **Date of Birth:** ____/____/____

Last **First** **MI**

SSN#: ______________ **Patient's relationship to insured:** ☐ Self ☐ Child ☐ Other: ______________

Insurance Co.: ______________ **ID #:** ______________ **Group #:** ______________

Insurance Co. Address: ____

Street **City** **State** **Zip Code**

Policy Holder's Employer:

SECONDARY

Policy Holder: ____ **Date of Birth:** ____/____/____

Last **First** **MI**

SSN#: ______________ **Patient's relationship to insured:** ☐ Self ☐ Child ☐ Other: ______________

Insurance Co.: ______________ **ID #:** ______________ **Group #:** ______________

Insurance Co. Address: ____

Street **City** **State** **Zip Code**

Policy Holder's Employer: ____

Patient Name: ______________________