



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 the 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
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

COMMENTS

MEDICAL HISTORY

1. Name of physician, family/pediatrician _____
 Phone _____
2. Does your child have a health problem?YES NO
3. Is your child under care of a physician?YES NO
 If yes, since when and why? _____
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.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

CHILD DENTAL MEDICAL HISTORY

welcome

Date _____

Patient's/Child's Name _____ Date of Birth _____ Male Female
Last First Initial**GUARANTOR INFORMATION:**

Mother's Name _____

D.O.B. _____

Address _____

City _____ State _____ Zip _____

Single Married Separated Divorced Widowed

Home Phone _____

Work Phone _____

Cell Phone _____

SS# _____

Place of Employment _____

Father's Name _____

D.O.B. _____

Address _____

City _____ State _____ Zip _____

Single Married Separated Divorced Widowed

Home Phone _____

Work Phone _____

Cell Phone _____

SS# _____

Place of Employment _____

Who is responsible for this account? _____

Referral Source _____

EMERGENCY CONTACT:

Name and phone number of person to be reached in case of emergency.

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

**DENTAL INSURANCE
1ST COVERAGE**

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

**DENTAL INSURANCE
2ND COVERAGE**

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE _____

REGISTRATION