Patient Information Form

Patient(s) Last name_____

Address _____

City _____Zip Code _____

Child 1 First name_____

Nickname_____

Birth date _____Sex: M F

Child 2 First name_____

Nickname_____

Birth date _____Sex: M F

Child 3 First name_____

Nickname_____

Birth date _____Sex: M F

Responsible Party

With whom does patient live? _____ Person responsible for account? _____

Who brought patient today? _____ Does patient have dental insurance? _____

Parent or Guardian Information

____Mother ____Stepmother ____Guardian

Name_____

Address_____

City_____ Zip Code_____

Mobile # _____

Home #_____

Work # _____

Email_____

____Father ____Stepfather _____Guardian

Name_____

Address_____

City_____ Zip Code_____

Mobile #_____

Home #_____

Work #_____

Email_____

Primary Insurance

Name of insured parent_____

Date of birth_____

ID number or SSN_____

Employer_____

Carrier_____

Group # _____

Secondary Insurance

Name of insured parent_____

Date of birth_____

ID number or SSN_____

Employer_____

Carrier_____

Group #_____

Whom may we thank for referring you to our office? _____

I have reviewed the information on this form and it is accurate to the best of my knowledge.

I also acknowledge that the Dental Materials Fact Sheet has been made available to me.

Signature of Parent/Guardian

X_____ Date_____

Dental and Medical Health History

Name_____ **Date of Birth** _____

Your child's health, as well as any medications which your child takes, can have an interrelationship with the dental care your child receives. Please answer each question completely.

How often does your child brush? _____
How often does your child floss? _____

Does your child:	**Yes**	**No**
Take fluoride supplements	____	____
Use pacifier	____	____
Suck thumb or finger	____	____
Suck or bite lip	____	____
Bite or chew nails	____	____
Grind teeth	____	____
Clench jaws	____	____
Gag easily	____	____
Was your child breastfed?	____	____
Age discontinued_____		
Was your child bottle-fed?	____	____
Age discontinued_____		

Has your child ever had the following? (please check any that apply below)

____autism ____anemia
____asthma ____mental disorder
____developmental delay ____brain injury
____speech disorder ____cancer
____cerebral palsy ____tuberculosis
____diabetes ____HIV/AIDS
____vision disorder ____bleeding disorder
____congenital heart defect ____my child is healthy
other_____

If your child had/has any of the above, please explain: _____
_____
_____

Current medications taken_____
Allergies or adverse reactions to any medications (e.g. penicillin, sulfas) _____
Allergies to any substances (e.g. latex) _____
Previous hospitalizations, surgeries, or serious illnesses, and date _____
Has your child had difficulty with previous dental visits? Y N Please describe _____
_____
Date of last dental visit_____ Child's pediatrician _____
Previous dentist _____ Pediatricians no. _____

Is there anything specific you'd like to discuss with Dr. Chris today? _____
_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary.

Signature of Parent/Guardian
X_____
Date_____