Child's Name_____Nickname _____Gender: _____Birth Date_____

Reason for this visit _____

Is this your child's first dental visit? ___ Date of last visit:_____Previous Dentist_____

Your child's attitude toward previous dental care? _____

How may we help to make your child's experience at our office as positive and comfortable as possible?_____

Have we seen other children in your family? _____ Names_____

How did you hear about our office? _____

MEDICAL INFORMATION

Dr.'s Name_____Address_____ _____ Phone_____

Is your child taking any medication? _____ If Yes, please list_____

Reason_____

Has your child ever been hospitalized? ___ When?_____ Reason_____

Are your child's immunizations current:? _____

Allergies to Medications or Food: _____

Is your child allergic or sensitive to latex?_____

Has your child had a history or difficulty with any of the following:

YES NO	YES NO	YES NO
▫▫Seasonal Allergies	▫▫Asthma/Reactive Airway Disease (RAD)	▫▫Arthritis
▫▫Autism	▫▫Anemia/Bleeding	▫▫Bones
▫▫Cancer/Tumors	▫▫Cerebral Palsy	▫▫Cleft Lip/Palate
▫▫Developmental	▫▫Diabetes	▫▫Eyes, Ears, Nose, Throat
▫▫Hearing	▫▫Heart	▫▫Kidney/Liver Liver
▫▫Hepatitis	▫▫Immune Deficiency	▫▫Stomach/Intestinal ▫▫Sleep Apnea/Snoring
▫▫General Anesthesia/Surgery	▫▫Seizures/Epilepsy/Convulsions	
▫▫Syndromes	▫▫Other	

Comments / Details _____

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ Or breast fed? _____ Until what age? _____

Does your child have any mouth habits, such as : finger/thumb sucking _____ pacifier _____ other _____

Has your child ever had any injuries to his teeth, mouth or head? _____ When? _____ Details _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____

Does your child floss? _____ Does an adult assist in flossing? _____

Has either parent or child been treated orthodontically? _____ Name of Orthodontist? _____

How would you expect your child to behave in our office? _____

Describe your child: Outgoing Shy Stubborn Anxious Frightened Age Appropriate

RESPONSIBLE PARTY 1:

First Name _____ Last Name _____Middle Initial ____

Address_____City, State, Zip _____

Primary Phone _____ Secondary Phone _____ Email _____

Relationship to Patient _____

RESPONSIBLE PARTY 2: (If applicable)

First Name _____ Last Name _____Middle Initial ____

Address_____City, State, Zip _____

Primary Phone _____ Secondary Phone _____ Email _____

Relationship to Patient _____

Emergency Contact:

First Name _____ Last Name _____Middle Initial ____

Address_____City, State, Zip _____

Primary Phone _____ Secondary Phone _____ Email _____

Relationship to Patient _____

Insurance:

Primary Dental Insurance (If Applicable):

Policy Owners Name _____Relationship to Patient: _____

Policy Owners date of birth: _____Social Security Number:_____-____-_____

Policy Owners employer: _____Employer's address: _____

Insurance company name: _____ _____

Plan, Local, or Group Number:_____ Policy I.D. Number: _____

Secondary Dental Insurance (If Applicable):

Policy Owners Name _____Relationship to Patient: _____

Policy Owners date of birth: _____Social Security Number:_____-____-_____

Policy Owners employer: _____Employer's address: _____

Insurance company name: _____ _____

Plan, Local, or Group Number:_____ Policy I.D. Number: _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to determine appropriate and healthful dental treatment. If there is any change in my child's medical status I will inform the dentist.

I authorize the dental insurance company provided to this office, to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize this signature on all insurance submissions

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

PATIENT/GUARDIAN NAME **SIGNATURE** **DATE**