Patient Information / Child or Teen

The following confidential information is important for the dentist to know in planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name		Email
Address		Date of Birth
City, State, Zip		School/Grade
Cell Phone	Home Phone	Hobbies/Pets/Interest

Account Information

Father's Name		Father's Date of Birth
Father's Employer	Position	Work Phone
Mother's Name		Mother's Date of Birth
Mother's Employer	Position	Work Phone
Dental Insurance Plan (If any)		Policy Number

Person responsible for account	Name and phone number of person to contact in case of emergency
How did you find out about this dental office?	

Health Information - Dental

Previous Dentist Address
Reason for this visit
Last dental check-up
Have you had a complete series of x-rays taken? When?
What do you feel is the present condition of your mouth?
Has anyone ever shown you how to clean your teeth?
Are you interested in regular dental care?
How often do you brush your teeth?
How often do you floss your teeth?

Do any of the following apply to you now or in the past?

Toothache	yes	no	Mouth Sores	yes	no
Cold Sensitivity	yes	no	Swelling in Mouth	yes	no
Heat Sensitivity	yes	no	Unpleasant Taste	yes	no
Pressure Sensitivity	yes	no	Smoker	yes	no
Sweet Sensitivity	yes	no	Grinding/Clenching	yes	no
Bleeding Gums	yes	no	Jaw Joint Noise	yes	no
Gums Hurt	yes	no	Locked Jaw	yes	no
Gum Treatment	yes	no	Improper Bite	yes	no
Loose Teeth	yes	no	Braces	yes	no
Bad Breath	yes	no	Unattractive Teeth	yes	no
Food Collects	yes	no	Other	yes	no

Health Information - Medical

Physician's Name Address / Phone	Are you allergic to:
Are you presently under the care of a physician? If yes, please explain.	List all medications or drugs (and dosages) that you ar taking.
Have you ever had a serious accident or illness? If yes, please explain.	
(Women) Are you pregnant? If yes, how long?	

Do any of the following apply to you now or in the past?

Heart Disease	yes	no	Thyroid Problem	yes	no	Tuberculosis, Lung Disease	yes	no	Tumors	yes	no
Rheumatic Fever	yes	no	Jaundice	yes	no	Astma, Hay fever	yes	no	Glaucoma	yes	no
Heart Murmur	yes	no	Hepatitis	yes	no	Sinus Problems	yes	no	Radiation Therapy	yes	no
Congenital Heart Defect	yes	no	Ulcers	yes	no	Epilepsy Convulsions	yes	no	Prosthetic Implant	yes	no
Abnormal Blood Pressure	yes	no	Diabetes	yes	no	Fainting Spells	yes	no	Venereal Disease	yes	no
Stroke	yes	no	AIDS/HIV	yes	no	Chemical Dependancy	yes	no	Arthritis	yes	no
Abnormal Bleeding	yes	no	Anemia	yes	no	Mental Health Care	yes	no	Other	yes	no

Penicillin	yes	no	Local Anesthetic	yes	no
Codeine	yes	no	Other	yes	no

The above information is correct to the best of my knowledge. I authorize the administration of such medication and performance of such diagnostic and therapeutic procedures as may be neccessary for proper dental care.

Parent Signature _____ Date_____

D.D.S. Signature _____ Date_____

Additional Info: _____