PATIENT NAME:_____ **DATE:**_____
Address:_____ City:_____ PC :_____
Child's Nickname:_____ Sex:_____ School:_____
Name of hobby, sport, toy or playmate special to your child:_____
Does child live with both parents? • Yes • No • Mother? • Father? • Guardian?
Parents email: _____
Father(guardian) complete name: _____DOB:_____
Home address (if different from child's):_____ Phone:_____
• Employed • Homemaker • Student • Retired • Other:_____ SIN #:_____
Employed by:_____ City:_____ Postal Code:_____
Present Position: _____ How long?_____ Work Phone:_____
Dental Insurance Company:_____ Group #:_____ Cert#_____
Mother(guardian) complete name: _____DOB:_____
Home address (if different from child's):_____ Phone:_____
• Employed • Homemaker • Student • Retired • Other:_____ SIN #:_____
Employed by:_____ City:_____ Postal Code:_____
Present Position: _____ How long?_____ Work Phone:_____
Dental Insurance Company:_____ Group #:_____ Cert#_____

Who is responsible for payment?_____ Phone number to call about appointments:_____
We first learned about this dental office from: • Yellow Pages • Newspaper • School • Work
Referred by: • Another patient/friend • Another patient/relative • Dental office doctor or staff member
• Other:_____ Name of person who referred us:_____

DENTAL HISTORY Is this your child's first visit to the dentist? • Yes • No
Has your child been having any specific problems? • Yes • No Describe:_____
Last dental visit:_____ Purpose:_____ Last complete exam:_____
Has your child experienced any unfavorable reaction from any previous dental or medical care? • Yes • No
Specify:_____
How would you describe your child's dental health? • Good • Fair • Poor
Do you think your child has active dental disease: Decay? • Yes • No Gum Disease? • Yes • No
Child's home care: Brush? • Yes • No Floss?**:** • Yes • No Other?**:** _____
Do your child's gums ever bleed? • Yes • No How often?:_____ Bad breath? • Yes • No
Does your child have any bad mouth habits? • Yes • No Specify:_____

MEDICAL HISTORY (Confidential. Repeated every 5 years) Birth date (mm/dd/yy):_____
Doctor's name:_____ Last physical exam:_____ Current age:_____
Does your child have any medical problems? • Yes • No Describe:_____
Is your child under a doctor's care now? • Yes • No If so, for what reason:_____
Is your child taking any medications? • Yes • No Please list:_____

• Heart disease	• Measles	• Tonsilitis	• Hepatitis	• Epilepsy	• Kidney disease/dialysis
• Heart murmur	• Mumps	• Jaundice	• Prolonged bleeding	• Fainting	• Allergy to medications
• Rheumatic fever	• Scarlet fever	• Asthma	• Herpes	• Seizures/convulsions	• Anesthetic allergy
• High blood pressure	• Typhoid fever	• Tuberculosis	• AIDS	• Psychiatric treatment	• Allergy to foods
• Diabetes	• Chicken Pox	• Arthritis	• Malignancies	• Prosthetic valves/joints	• Other allergies:

List all of your child's allergies here: _____

AUTHORIZATION: I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.
Child's Parent/Guardian signature: _____ Date:_____