Patient Information

If patient is a minor, this form is to be filled out by parent or guardian

Parent/Guardian Information

Name: ____
Last First MI Preferred

Birthdate: (M/D/YYYY) __________ SS#: ____________________ | Gender: ☐M ☐F ☐Other | Married: ☐Y ☐N

Work Phone ______________ Wireless Phone ______________ Home Phone ______________

Email Address ____

Preferred Contact Method ☐Hm Phone ☐Wk Phone ☐Wireless Phone ☐Email

Preferred Contact Method for Confirmations ☐Hm Phone ☐Wk Phone ☐Wireless Phone ☐Email

Preferred Method for Recall ☐Hm Phone ☐Wk Phone ☐Wireless phone ☐Email

How did you hear about us?

____

If someone referred you here, please write down their name so we can thank them.

____

Address

Check box if same for the entire family ☐

Address: ____

Address 2: ____

City ____________________ State ______ Zip __________

Insurance Policy 1

Your relationship to Subscriber ☐Self ☐Spouse ☐Child

Subscriber name ______________________ Subscriber ID ______________

Subscriber DOB (MM/DD/YYYY) ____________________

Insurance Company ______________________ Insurance Phone # ______________

Employer ______________ Group name ______________ Group # ______________

Please present insurance card to the receptionist

Insurance Policy 2

Your relationship to subscriber ☐Self ☐Spouse ☐Child

Subscriber name ______________________ Subscriber ID ______________

Subscriber DOB (MM/DD/YYYY) ____________________

Insurance Company ______________________ Insurance Phone # ______________

Employer ______________ Group Name ______________ Group # ______________

Comments:

____

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, ____________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ______________________ Date: __________ Initial if you refuse to sign ______

Comprehensive Medical & Dental Form

Last Name: ______________ First Name: ______________ Birthdate: (M/D/YYYY) ________

Name of Medical Doctor: ______________________ City/State: ______________

Name of Pharmacy __________ Address __________ Phone #:

Reason for today's visit ______________________

New patients:

Has your child taken a Panoramic x-ray or Full Mouth x-rays within the past 5 years? ______________

Has your child taken BiteWing (cavity detecting) x-rays within the past year? ______________

Dental Information

	Y	N	
Has your child ever been examined by another dentist?	☐	☐	Name of former dentist ______________
Date of last cleaning and exam ______________			
Has your child complained of dental problems/pain?	☐	☐	
Has your child had any unpleasant dental experiences?	☐	☐	Please specify ______________
Has your child had any injuries to the mouth, teeth, or head?	☐	☐	Please specify area of injury and date of occurence: ______________
Does your child perform any of the following behaviors?			
Thumb Sucking	☐	☐	
Pacifier	☐	☐	
Tongue thrust	☐	☐	
Nighttime mouth breathing or Snoring	☐	☐	
Does your child brush their teeth daily?	☐	☐	Once ☐ Twice ☐ Assisted ☐ Unassisted ☐ Supervised ☐ With Fluoride toothpaste ☐ WithOUT Fluoride toothpaste ☐
Is your water fluoridated?	☐	☐	
Does your child take a Fluoride supplement	☐	☐	Please specify: ______________

Medical Information

Do your child have a history of, or difficulty with any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems/ Clotting disorder	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Anemia
☐	☐	Diabetes	☐	☐	ADHD or similar condition
☐	☐	Heart Murmur/Problem	☐	☐	Sinus Trouble
☐	☐	Cerebral Palsy	☐	☐	Epilepsy/Seizure disorder
☐	☐	Developmental Delay	☐	☐	Tuberculosis
☐	☐	Autism or Similar condition	☐	☐	Rheumatic Fever
			☐	☐	Other

If you answered yes to any of the above, please give a brief description of the condition and severity

____

____

Has your child ever been hospitalized for any of these or any other medical conditions?

☐ Yes, Please specify cause, approximate date and outcome: ______________________________

☐ No

Has your child ever had any surgical procedures performed under General Anesthesia?

No ☐ Yes ☐ Any complications? ______________________________________

Is your child taking any prescription or over the counter medications/supplements? Yes ☐ No ☐

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Is your child allergic to any of the following?

Y	N		Y	N	
☐	☐	Penicilin/Amoxicillin	☐	☐	Food dye Specify ____________
☐	☐	Aspirin or Ibuprofen	☐	☐	Latex
☐	☐	Milk	☐	☐	Dogs/Cats/Pet dander
☐	☐	Eggs	☐	☐	Nickel (metals)
☐	☐	Other ______________________________			

Unusual reaction to dental injections? ______________________________

Parent/Guardian Info

Name of Parent/Guardian filling out this form ______________________________

Title (Mom. Dad, legal guardian, etc.) ______________________________

Date: MM/DD/YYYY ____________ City/State

Signature: ______________________________