**Patient Info**

First: Middle: Last: Male Female

Preferred Name: DOB: / / Height: Weight: lbs

Address: Apt#: City: State: Zip:

**Primary Guardian’s Info**

Relation:

Name:

Phone: Cell Home

Alt Phone: Cell Work

Email:

DOB: / /

**Secondary Guardian’s Info**

Relation:

Name:

Phone: Cell Home

Alt Phone: Cell Work

Email:

DOB: / /

Referred by: Dentist Primary Care Dr Google Yelp Website Another Patient Other:

Other Emergency Contact: Phone:( ) Relation to Patient:

**Dental Insurance Subscriber/Policy Holder Info**

Insurance: ID/SSN:

Subscriber/P.H. Name: Subscriber/P.H. DOB: / /

Ins Phone:( ) Group: Relation to Pt:

**Medical History**

Child’s Primary Physician: Phone:( )

Location: Address:

Is your child in good health? Yes No

Has your child ever had any health problems or been hospitalized for health reasons? Yes No

 If yes, please describe:

Is your child now taking any prescriptions or over the counter medications?  Yes No

 If yes, please list:

Have you ever been told that your child needs to take antibiotics before treatment? Yes No

 If yes, name of physician or dentist: Phone:( )

**Allergies**

Has your child ever had any allergic reaction to: Food Medication Latex Metal Other:

**Medical Conditions**

Please indicate if your child has any of the following:

**General Conditions Behavior/Learning Conditions**

Asthma Yes No

Arthritis Yes No

Diabetes Yes No

GI Disorder Yes No

Heart Disease Yes No

Kidney Disease Yes No

Rheumatic Fever Yes No

ADHD Yes No

Anxiety/Nervousness Yes No

Autism Yes No

Emotional Disability Yes No

Learning Disability Yes No

Behavior Issues Yes No

Psychiatric Disorder Yes No

**Developmental Delay Conditions**

Brain Injury Yes No

Cerebral Palsy Yes No

Cleft Lip/Palate Yes No

Developmental Delay Yes No

Orthopedic Problems Yes No

Growth Problems Yes No

Fainting/Seizures Yes No

Speech Problems Yes No

Hearing Loss Yes No

Neuromuscular Defect Yes No

**Infectious Conditions Blood Related Conditions**

Hepatitis Yes No

HIV / AIDS Yes No

Tuberculosis Yes No

Anemia Yes No

Bleeding (Abnormal) Yes No

Hemophilia Yes No

**Other Conditions**

Cancer Yes No

Epilepsy Yes No

Leukemia Yes No

Down Syndrome Yes No

Tourette Syndrome Yes No

Severe Headaches/Migraines Yes No

Gag Reflex Yes No

Sleep Apnea Yes No

Sleep Disorder Yes No

Excessive Snoring Yes No

Does your child have any disease, condition, or problem not listed above that you think we should know about?

 If yes, please explain:

**Dental History**

Is this your child’s first visit to the dentist? Yes No

If no, when was the last visit? Previous Dentist:

Phone:( ) Office Location:

Please check any of the following that may describe your child’s attitude towards dentistry

Friendly Cooperative Anxious Shy Uncooperative Unfriendly

**Dental History (continued)**

Has your child ever had an unhappy dental experience? Yes No

Has your child ever had local anesthetic (Novocain)? Yes No

If yes, were there any problems?

Please check if your child has any of the following:

Cavities Yes No

Gum Infection Yes No

Toothache Yes No

Crowding/Spacing of Teeth Yes No

Sensitive Teeth Yes No

Discolored Teeth Yes No

Trauma Yes No

Other:

Is there anything else that you would like to tell us regarding your child’s dental health?

**Habits**

Does your child brush his/her teeth daily? Yes No Do they floss? Yes No

Do you assist in brushing your child’s teeth? Yes No

Does your child take fluoride in any form? Tablets Drops Water Paste/Gel Rinse None

Does your child have any of the following habits?

Nursing Bottle Yes No

Nail Biting Yes No

Thumb/Finger Sucking Yes No

Mouth Breathing Yes No

Pacifier Sucking Yes No

Grinding Teeth Yes No

Cheek/Lip Biting Yes No

Clenching Jaw Yes No

How often does your child have sugar snacks? (candies, gum, etc.) per day per week

How many cups of soda or juice does your child drink? per day per week

**Patient/Legal Guardian**

**Signature: Date: / /**

**Print Name: Relation to Patient:**