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Chart #:_____
FOR OFFICE USE ONLY

## Patient Information

Patient Name: _____ Date: _____
Last First MI

❑ Male ❑ Female ❑ Other family members seen by us _____

Social Security #: _____ Birth Date: _____ Age_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ Nearest Relative _____ Phone_____
Emergency Contact (Not Living With You)

Previous Dentist: _____

## Mother's Information

Name: _____ Birth Date: _____

Address: _____
If Different From Patient Street City State Zip Code

Phone(home)_____ (work)_____ Cell_____ SS #_____

Email Address to Confirm: _____ Text to confirm? ❑ Yes ❑ No

Employer: _____

## Father's Information

Name: _____ Birth Date: _____

Address: _____
If Different From Patient Street City State Zip Code

Phone(home)_____ (work)_____ Cell_____ SS #_____

Email Address to Confirm: _____ Text to confirm? ❑ Yes ❑ No

Employer: _____

## Insurance Information

**Primary**
Name of Insured: _____
Last First MI

Relationship to Patient: _____

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insurance Plan Name,
Address and Phone Number _____

_____

_____

_____

**Secondary**
Name of Insured: _____
Last First MI

Relationship to Patient: _____

Insured's Birth Date: _____ ID #: _____ Group #:_____

Plan Name, Address
and Phone Number _____

_____

_____

_____

## Responsible Party Information

The following person is responsible for account: ❑ Mother ❑ Father

Name: _____

❑ Married ❑ Single ❑ Divorced ❑ Separated_____

## Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

**Has your child ever had any of the following? Please check those that apply:**

❑ AIDS/HIV
❑ Bleeding Problems
❑ Blood Disorder
❑ Cancer
❑ Rheumatic Fever
❑ Diabetes
❑ Convulsions
❑ Hepatitis
❑ Liver Disease

❑ Asthma
❑ Kidney Disease
❑ Heart Defect/Murmur
❑ Stomach Problems
❑ Tuberculosis
❑ Penicillin Allergy
❑ Drug Allergies
❑ Handicaps/Disabilities
❑ Operations

❑ Thumb/finger sucking
❑ Lip biting/sucking
❑ Nursing bottle habit
❑ Frequent snacking

❑ On Medications Now
_____
_____
_____
_____

❑ Allergies
_____
_____
_____
_____

❑ Comments:

• Does your child brush daily? ❑ Yes ❑ No

• Does your child floss daily? ❑ Yes ❑ No

• Is your child taking fluoride supplements? ❑ Yes ❑ No

• Has your child ever had any complications following dental treatment? ❑ Yes ❑ No
If yes, please explain:_____

• Has your child been admitted to a hospital or needed emergency care during the past year? ❑ Yes ❑ No
If yes, please explain:_____

• Is your child now under the care of a physician? ❑ Yes ❑ No
If yes, please explain:_____

• Name of Physician:_____Phone:_____

• Does your child have any health problems that need further clarification? ❑ Yes ❑ No
If yes, please explain:_____

## Referral Information

Whom may we thank for referring you to our practice?_____

## Consent for Services

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ Date:_____ Relationship to Patient:_____

Signature of parent or guardian