PATIENT INFORMATION

NAME: _____
Last *First* *Middle Initial*

BIRTHDAY: _____ / _____ / _____ **AGE:** _____ **WEIGHT:** _____

SOCIAL SECURITY NUMBER: _____ - _____ -_____ **BIOLOGICAL SEX AT BIRTH:** MALE / FEMALE

Have we seen another child in your family? If yes, who? _____

What is your child's favorite (pet, sport, toy?): _____ **Who referred you to our office:** _____

Who is your Family dentist? _____

Child currently lives with: Mother Father Both Grandmother Grandfather Other: _____

YOUR CHILD'S MEDICAL / DENTAL HISTORY

Does your child have any dental problems that you are aware of?
If yes, please explain: _____

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor

HAS YOUR CHILD:

☐ Yes ☐ No **Ever visited the dentist before?**
When? _____ **Were x-rays taken?** _____

☐ Yes ☐ No **Ever had an unfavorable dental/medical visit?**
If yes, please explain: _____

☐ Yes ☐ No **Exhibited any undesirable mouth habits?**
If yes, please explain: _____

☐ Yes ☐ No **Exhibited TMJ / TMD or tooth grinding problems?**

IS YOUR CHILD:

☐ Yes ☐ No **Currently under the care of a physician / specialist?**
Child's Physician _____ Phone #: _____
Child's Specialist _____ Phone #: _____

☐ Yes ☐ No **Currently taking ANY prescription/non-prescription medication(s) or dietary/herbal supplement(s)? If yes, please list:**
_____

☐ Yes ☐ No **ALLERGIC TO ANY MEDICATIONS OR FOOD PRODUCTS?**
PLEASE LIST: _____

☐ Yes ☐ No **ALLERGIC to LATEX products?**

☐ Yes ☐ No **Currently taking any birth control?**

☐ Yes ☐ No **Does your child require antibiotic coverage prior to dental treatment due to heart murmurs/shunt, etc.?**

PLEASE CIRCLE "YES" or "NO" AS IT RELATES TO YOUR CHILD'S HEALTH:

YES	NO	Heart Murmur
YES	NO	Heart Problems of any kind
YES	NO	Shunts
YES	NO	Cancer
YES	NO	Diabetes
YES	NO	Rheumatic Fever
YES	NO	HIV positive / AIDS
YES	NO	Hemophilia
YES	NO	Bleeding problems of any kind
YES	NO	Hearing Impairment
YES	NO	Hyperactive
YES	NO	Frequent Headaches
YES	NO	Asthma - Last attack: _____
YES	NO	Convulsions/Epilepsy/Seizures
YES	NO	Pregnancy
YES	NO	Physical/Mental Impairment
YES	NO	Learning Disability
YES	NO	Autism
YES	NO	Dermatologic / Skin Conditions
YES	NO	Any hospital stays/operations:

If yes, please list: _____