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Today's Date _____

Patient's Name _____ Age _____ Birthdate _____
Address_____ ☐ Male ☐ Female
City _____ State_____ Zip_____ Home Phone # _____
Parent's Marital Status_____ Best e-mail for contact_____

Father's Name _____
Father's Cell Phone _____
Address (if different than child) _____
_____
_____
Father's SSN _____
Father's DOB _____
Father's Employer _____
Work # _____
Father's Dental Insurance _____

Mother's Name _____
Mother's Cell Phone _____
Address (if different than child) _____
_____
_____
Mother's SSN_____
Mother's DOB _____
Mother's Employer _____
Work # _____
Mother's Dental Insurance _____

Dental History

Date of last dental visit _____

	Yes	No
Reason for dental visit _____		
Has patient complained about dental problem?_____	☐	☐
Any unhappy dental experiences? _____	☐	☐
Any injuries to mouth, teeth, head? _____	☐	☐
Any mouth habits, thumb sucking, nail biting, mouth breathing, etc.? _____	☐	☐
Is child in good health? _____	☐	☐
Is child under physician's care? _____	☐	☐

If yes, please give reason for treatment _____
_____

Physician's Name_____ Phone # _____

Is the patient taking any medications at this time? If so, what medication? _____	☐	☐
Has the patient ever been hospitalized? _____	☐	☐
Has the patient had surgery or been under general anesthesia?_____	☐	☐

(turn over please)

Dental History Continued

	Yes	No
Does patient have any allergies? _____	☐	☐
_____		
Has the patient had any unusual reaction to an anesthetic or drug (like penicillin)?_____	☐	☐
Has the patient ever experienced excessive bleeding? _____	☐	☐
Are there any emotional problems? _____	☐	☐

HAS CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING:

_____ Anemia	_____ Diabetes	_____Glaucoma	_____ Rheumatic Fever
_____ Asthma	_____ Epilepsy	_____ Kidney	_____ Measles
_____ Cerebral Palsy	_____ Fainting	_____ Liver	_____ Mumps
_____ Convulsions	_____ Hearing	_____ Infectious Hepatitis	_____ Thyroid
_____ Chickenpox	_____ Heart	_____ AIDS	_____ Tuberculosis

Is there any other information that should be known about the child's health? _____

_____

_____

Payment Terms: Payment is expected at the time services are rendered, but no later than sixty (60) days after the date of service. Any balance remaining due after ninety (90) days is considered past due.

Costs of Collection: If this account becomes past due, I understand that this account may be referred to an attorney and/or other collection service for collection. I agree to pay for the costs of collection, including attorney fees, incurred in pursuit of collecting this account. I acknowledge that I have filled out this form truthfully and accurately to the best of my knowledge and agree by all of the terms and conditions as set forth above.

Signature of Person Responsible_____

Relationship to Child_____

Referred by_____