PATIENT INFORMATION

*MEDICAL AND DENTAL HISTORY QUESTIONS ARE NECESSARY FOR SAFE AND APPROPRIATE DENTAL CARE. INADEQUATE OR INCORRECT INFORMATION COULD BE DANGEROUS TO YOUR CHILD/LEGAL WARD'S HEALTH. PLEASE ANSWER ALL QUESTIONS COMPLETELY. IF YOU HAVE QUESTIONS, PLEASE ASK FOR ASSISTANCE. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Child's Name _____ M___ F___ Preferred Name _____ Age _____ Birthdate _____
First Middle Last

Child's School (name) _____ (city) _____

With whom does the child reside? _____ Parent's Marital Status _____

Father/Legal Guardian _____	Mother/Legal Guardian _____
Address _____	Address _____
City _____	City _____
State _____ Zip _____	State _____ Zip _____
Home Phone _____ Cell Phone _____	Home Phone _____ Cell Phone _____
Occupation _____	Occupation _____
Name of Employer _____	Name of Employer _____
Address _____	Address _____
Business Phone _____ Ext. _____	Business Phone _____ Ext. _____
Birthdate _____	Birthdate _____
SSN _____	SSN _____

Is the child covered by ADC or Medicaid? ❑ yes ❑ no If yes, reference number _____

Are any siblings patients here? (name/age) _____

How did you hear about our office: ❑ Family / Friend _____ ❑ School Visit / Molar the Polar Bear
❑ Yellow Pages ❑ Health / Baby Fair ❑ Newspaper
❑ Referring Dentist _____ ❑ Parade _____
❑ Other _____

MEDICAL HISTORY

*IMPORTANT INFORMATION: MEDICATIONS THE DENTIST USES IN ROUTINE DENTAL TREATMENT MAY INTERACT WITH BOTH PRESCRIPTION AND STREET DRUGS. IT'S EXTREMELY IMPORTANT THAT YOU INFORM THE DENTIST OF ANY DRUG YOUR CHILD IS TAKING SO THAT THIS MAY BE CONSIDERED IN DENTAL TREATMENT PLANNING. THIS INFORMATION WILL BE HELD IN STRICT CONFIDENCE AND USED ONLY FOR SAFE, APPROPRIATE DENTAL CARE.

Child's Physician's Name _____ Phone _____

Physician's Address (city) _____ (state) _____ (zip) _____

Date and findings of last complete physical exam _____

Is your child ALLERGIC to any medicine, food, or substance? _____

Has your child ever bled excessively from a cut or injury or bruised easily? _____

Does your child have any history of or medical problems with any of the following? (Please check)

___ Heart Disease	___ Digestion	___ Anemia	___ Epilepsy or Seizures	___ HIV Positive / AIDS
___ High Blood Pressure	___ Kidney / Bladder	___ Diabetes	___ Fainting or Dizziness	___ Hepatitis
___ Heart Murmur	___ Gastric Reflux	___ Thyroid Disease	___ Emotional Problems	___ Liver Disease
___ Rheumatic Fever	___ Respiratory / Lungs	___ Radiation Therapy	___ Psychiatric Treatment	___ Yellow Jaundice
___ Congenital Heart Lesions	___ Down's Syndrome	___ Chemotherapy	___ Physical Handicap	___ Blood Transfusion
___ Scarlet Fever	___ Tuberculosis (TB)	___ Cancer	___ Cerebral Palsy	___ Hemophilia
___ Artificial Heart Valve	___ Asthma	___ Cleft Lip / Palate	___ Hyperactivity	___ Sickle Cell Disease
___ Heart Pacemaker	___ Immune Deficiency	___ Tubes in Ears	___ Attention Deficit Disorder	___ Mononucleosis
___ Heart Surgery	___ Sinus Trouble	___ Hearing	___ Learning Disorder	___ Bruise Easily
___ Artificial Joint	___ Seasonal Allergies	___ Arthritis	___ Mental Retardation	___ Smoking
___ Developmental Delay	___ Depression	___ Autism	___ Alcohol / Drug Use	___ Pregnancy

Any special problems not listed above? _____

Does your child have any illness now? _____

Name(s) of any medication(s) taken recently by your child _____

_____

_____

Has your child ever been hospitalized? _____ Date and Reason: _____

over

Email: _____

DENTAL HISTORY

What is your main reason for bringing your child to this office? _____

Is this your child's first visit to a dentist?_____ If not, when was the last visit?_____

And why?_____Who was the dentist? _____

Has your child had any unusual reactions to a dental anesthetic? _____

How does your child feel about going to the dentist? _____

Please explain any adverse reactions to dental treatment _____

Does your child have a history of: (Please check)

___ Thumb Sucking ___ Nail or Object Biting ___ Speech Problems ___ Teeth Grinding

___ Mouth Breathing ___ Tongue Thrusting ___ Other Oral Habits

Is your child presently being seen by an orthodontist? _____ If so, whom? _____

Has there ever been any injury to the mouth or any of the teeth? _____

Does your child drink fluoridated water? ❑ Yes ❑ No ❑ Unknown

Sports activities in which your child participates_____ Is a mouthguard worn? _____

Child's interests, hobbies, talents, etc. _____

Are there any questions you would like answered? (Please list)_____

_____

Do you have any specific concerns about your child's dental treatment? _____

PERMISSION

I understand 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/legal ward's medical status.

I hereby give authorization as a parent or guardian to Drs. Richards, Miller and Associates for the completion of all agreed upon dental services and agree to become personally responsible for such financial obligation incurred. I also understand and agree that said dental treatment may include the use of any necessary or advisable local anesthesia, sedatives, radiographs (x-rays), or diagnostic aids. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the treatment or as to the cure.

I hereby state that I have read and understand the consent; and I understand that I have the right to be provided with answers to questions which might arise during the course of my child's (or legal ward's) treatments. I also grant permission to this office to communicate with my medical doctor concerning my child's/legal ward's health status.

I further state that this consent will remain in effect until such time that I choose to terminate it.

_____

Signature Relationship Date

ANNUAL UPDATE

I have reviewed the information on this sheet. All changes have been marked and the information is correct.

_____

Signature Relationship Date

_____

Signature Relationship Date

_____

Signature Relationship Date

Thank you for taking the time to give us all of this vital information. It will help us to give your child the best care possible.