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Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_

Last Dental Visit \_\_\_\_\_ Child's Previous Dentist \_\_\_\_\_

Purpose of this Visit \_\_\_\_\_

Who may we thank for referring you to our office \_\_\_\_\_

Child's School \_\_\_\_\_ Names of Child's Siblings \_\_\_\_\_

### Health History

Child's Physician \_\_\_\_\_

Is your child adopted? \_\_\_ No \_\_\_ Yes If yes, is your child aware? \_\_\_\_\_

Is your child under a physician's care now? \_\_\_\_\_ Reason \_\_\_\_\_

Is your child taking any medication or drugs? \_\_\_\_\_ What kind \_\_\_\_\_ Reason \_\_\_\_\_

Is your child allergic to any medication? \_\_\_\_\_ Please List \_\_\_\_\_

Does your child have allergic reaction(s) to: food \_\_\_\_\_ animals \_\_\_\_\_ pollen \_\_\_\_\_ dust \_\_\_\_\_ latex \_\_\_\_\_ other \_\_\_\_\_

Does your child have any of these habits: finger/thumb habit \_\_\_\_\_ pacifier \_\_\_\_\_ nail biting \_\_\_\_\_ teeth grinding \_\_\_\_\_  
lip sucking \_\_\_\_\_ snoring \_\_\_\_\_ mouth breathing \_\_\_\_\_ nursing bottle \_\_\_\_\_

Has your child had any injuries to teeth, mouth or head? \_\_\_\_\_ Describe \_\_\_\_\_

Has your child had a history or difficulty with any of the following?

YES NO	YES NO	YES NO	YES NO
_____ Premature Birth	_____ Delayed Development	_____ Emotional Problems	_____ Nosebleeds
_____ Heart	_____ Motion Sickness	_____ Speech Disorder	_____ Asthma
_____ Seizures	_____ Earaches	_____ Hearing	_____ Liver
_____ Immune Disorder	_____ Kidney	_____ Bone Disorder	_____ Cerebral Palsy
_____ Brain Injury	_____ Rheumatic Fever	_____ Diabetes	_____ Bruising
_____ Fainting or dizziness	_____ Tuberculosis	_____ Hepatitis	_____ Bladder
_____ Anemia	_____ Cancer or Malignancies		

### General Information

Parent/Guardian #1 \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer/Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer/Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Do you have dental insurance coverage for your child? \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_ Address of Ins. Company \_\_\_\_\_

IF YOU HAVE DUAL COVERAGE, PLEASE COMPLETE BELOW FOR SECONDARY CARRIER;

Name of Insured \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_ Address of Ins. Company \_\_\_\_\_

The permission of parent or guardian is necessary for dental treatment. I give the dentists permission to use such measures as deemed necessary in their professional judgment to render the best dental treatment for my child including the use of anesthetics and medication considered necessary. Parents will be consulted before any treatment is started.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_