



We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Thank You!

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### PATIENT INFORMATION

Patient Name \_\_\_\_\_  Male  Female  
Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Phone # \_\_\_\_\_  home  cell Ok to leave Message?  Y  N  
Email \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
List any sports or extracurricular activities \_\_\_\_\_  
Siblings (names and ages) \_\_\_\_\_

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### PARENT / GUARDIAN INFORMATION

Parent's Marital Status  Single  Married  Divorced  Widowed  Significant Other  
 Mother  Step-Mother  Guardian  Other Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Driver License # \_\_\_\_\_  
Address (if different than child's) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  home  cell Secondary Phone # \_\_\_\_\_  home  cell  
Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
  
 Father  Step-Father  Guardian  Other Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Driver License # \_\_\_\_\_  
Address (if different than child's) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  home  cell Secondary Phone # \_\_\_\_\_  home  cell  
Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

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### EMERGENCY CONTACT

Emergency Contact Name (other than parent) \_\_\_\_\_  
Phone # \_\_\_\_\_ Relation to child \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person(s) OK to release appointment or medically related information to concerning child.  
\_\_\_\_\_ Relation(s) \_\_\_\_\_

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## INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Member ID # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Relation \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Birth Date \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Co-pay (if known) \_\_\_\_\_ Deductible (if known) \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Member ID # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Relation \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Birth Date \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Co-pay (if known) \_\_\_\_\_ Deductible (if known) \_\_\_\_\_

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## DENTAL HISTORY

How did you hear about our Practice?

Ad  Internet  Family or Friend  Physician  Other

Name of person referring (if applicable) \_\_\_\_\_

Have we treated any other family members?  Y  N Name \_\_\_\_\_

Have your child's tonsils or adenoids been removed?  Y  N

Has your child ever experienced jaw joint pain/discomfort (TMJ/TMD)?  Y  N

Does your child have any missing or extra permanent teeth?  Y  N

Has your child ever had an injury to (*select all that apply*):  Teeth  Mouth  Chin

Does your child have speech problems?  Y  N If so, explain \_\_\_\_\_

Does your child currently or has your child ever had any of the following habits

(*check all that apply*)

Clenching/Grinding Teeth

Mouth Breathing

Thumb / Finger Sucking

Lip Sucking/Biting

Nail biting

Chewing / Eating Problem

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## MEDICAL HISTORY

Is your child currently being treated by a physician?  Y  N Reason \_\_\_\_\_

Physician \_\_\_\_\_ Last Visit \_\_\_\_\_ Phone \_\_\_\_\_

Does your child have any allergies/sensitivities to medications or latex?  Y  N

If yes, please list. \_\_\_\_\_

Is your child currently taking any prescription or over-the-counter medications?  Y  N

Please list, with dosage. \_\_\_\_\_

Has puberty and/or menstruation begun?  Y  N  N/A

Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?  Y  N

Has your child had any serious illnesses or operations? If yes, describe:

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Has your child ever had a blood transfusion?  Y  N

If yes, give approximate dates: \_\_\_\_\_

Is your child pregnant?  Y  N    Nursing?  Y  N    Taking birth control pills?  Y  N

Check if your child has or has ever had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Coughing Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

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## AUTHORIZATION

- ❖ I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status.
- ❖ I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- ❖ I understand that where appropriate, credit bureau reports may be obtained.

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Patient Signature and/or Responsible Party

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Date