Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you; your records are confidential. If you need help please ask us – we will be happy to assist you.

*****Please Note That You Are Answering These Questions for Your CHILD And Not Yourself*****

MEDICAL

The name, address and phone number of my pediatrician is _____

_____

Are you under a physician's care now? ○Yes ○No _____

Did you have a full term pregnancy with your child? ○Yes ○No _____

Have you ever been in the NICU, hospitalized or had a major operation? ○Yes ○No _____

Have you ever had a serious head or neck injury? ○Yes ○No _____

Are you taking any medications, pills, or drugs? ○Yes ○No _____

Does you child have ADD, ADHD, PDD, Autism, or on the spectrum? ○ Yes ○No _____

Are you on a special diet (Gluten free, no red dye, etc) ? ○Yes ○No _____

TEENAGE Women: Are you ○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Amoxicillin □ Gluten □ Metal □ Latex □ Local Anesthetics

□ Any other medicines or Foods. If yes please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Preasure ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Stroke ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Liver Disease ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Lung Disease ○ Yes ○ No	Tonsilitis ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pace Maker ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to me or my child's health. If I ever have any change in my health or change in my medication, I will inform the dentist, hygienist, or the dental office.

_____ / _____
Signature of Patient (or legal guardian) Date

_____
Relationship to patient (Mom, Dad, etc)

_____ / _____
Signature of DENTIST Date

_____ / _____
Signature of HYGIENEST Date

QUESTIONNAIRE

Name_____ Birth Date_____
Name child would like to be called "_____"
Address_____Town _____
Phone number_____Email _____
Parent's work #_____Parent's cell #_____
Is anyone in your family currently a patient within our practice? _____
_____
Whom may we thank for your referral or how did you find us? _____

RESPONSIBLE PARTY

Name of person responsible for this account_____Relationship _____
Billing Address, etc (if different from above)_____
Responsible phone #_____Responsible SS#_____
Phone # for appointment confirmations _____
Please be aware that the person who brings in the child is ultimately responsible for consent and final payment. We understand that some of our patients have legal agreements with a former spouse, etc. If this is your case, then you must bring in a notarized letter as such or you will be responsible.
Please initial here that you have read the above paragraph and understand it. X_____

INSURANCE INFORMATION

Name of insured_____ Relationship_____
Birthdate_____SS#_____ Date of employed _____
Name of employer_____Union or Local #_____ Work phone#_____
Address of employer_____City_____State_____Zip_____
Insurance Company_____ Group #_____ID# _____
Ins. Co. Address_____ City_____State_____Zip_____
How much is your deductible?_____How much have you used?_____ Max benefit_____
*Please be aware: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group for insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that insurance estimates are just that and may reflect inaccurate information. It is my responsibility to inform the office of any and all changes to my insurance.
Please initial here that you have read the above paragraph and understand it. X_____

DENTAL

1. Are you having any discomfort at this time?.....Yes No
2. Have you ever had any serious trouble with previous dental treatment?.....Yes No
   If so, explain_____
3. Does dental treatment make your child nervous? No_____ Slightly_____ Moderately_____Extremely_____
4. Date of last dental visit (or is this your first visit?) _____
5. If not first, then name of previous dentist _____
6. Does your child do any of the following? Please circle the "underlined" answer or the "Yes or No"

- Brush in the am / pm / both?
- Brush as the last thing in your child's mouth before bed.....Yes No
- Brush with help or on their own?
- How many times a day does your child brush? _____
- Use fluoride tooth paste or Non Fluoride toothpaste?
- Do they take vitamins with Fluoride? Yes No
- Does your child use a rinse? Fluoride(like ACT) Perio(like Listerine)
- Do they use dental floss?...Yes No
- Any habits? thumb sucker, finger sucker, pacifier, tongue thrust, other_____? If yes, is it still active / past.
- Did your child take a bottle to bed, sippy cup to bed, nurse in the middle of the night? If yes, is it still active / past.
- Would you consider your child to be a healthy eater? Yes No
- How many snacks in a day do they eat? _____
- Clenching, grinding.....Yes No
- Sensitive teeth.....Yes No