CHILD'S NAME _____NICKNAME_____AGE_____ DATE OF BIRTH_____

RESIDENCE ADDRESS_____CITY _____ STATE_____ ZIPCODE_____

FATHER'S NAME_____ EMPLOYED BY _____ HOME/CELL #_____ WORK # _____

MOTHER'S NAME _____ EMPLOYED BY _____HOME/CELL #_____ WORK #_____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____ RELATIONSHIP TO CHILD _____

ADDRESS _____ CITY_____ STATE _____ ZIPCODE _____ PHONE #_____

DO YOU HAVE DENTAL INSURANCE ?_____ NAME OF PERSON CARRYING INSURANCE _____ DATE OF BIRTH_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHAT IS YOUR CHILD'S FAVORITE SPORT/HOBBY? _____

SCHOOL CHILD ATTENDS_____ GRADE _____

DENTAL HISTORY

Is this your child's first visit…… Yes No
If not, how long since your child has seen a dentist…… Yes No
Has child complained about dental problems …….. Yes No
Any unhappy dental experiences …… Yes No
Any injuries to mouth-teeth-head …… Yes No
Any mouth habits – thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. Yes No
Have missing teeth been replaced …… Yes No
Orthodontic appliances worn now or ever …….. Yes No

Does your child brush daily …….. Yes No
Do you assist child with tooth brushing …….. Yes No
Is dental floss used_____ How often _____
Are disclosing tablets used …… Yes No
Is fluoride taken in any form …… Yes No

Child's attitude toward dentistry_____
Comments: (What would you like done for your child)
_____

HEALTH HISTORY

Is child under care of physician now…… Yes No
Is child receiving any medication or drugs …… Yes No
Is there excessive bleeding when cut …… Yes No
Has child ever been hospitalized …… Yes No
Is there any allergies to penicillin or other drugs…….. Yes No
Is there any emotional problems …… Yes No

Has child had any history of or difficulty with any of the following:

Anemia _____	Fainting _____	Asthma _____
Heart _____	Diabetes _____	Kidney _____
Liver _____	Convulsions ___	Epilepsy _____

Are there any current or past medical problems? _____