

Welcome to ABC Dentistry for Children

CHILD'S INFORMATION

Today's Date _____

Child's Name: _____ Birthdate _____ Age _____ M ___ F ___

Child's Address _____

_____ City _____ State _____ Zip _____

Child's favorite activities _____

PARENT'S INFORMATION

Who brought the child today? Name _____ Relation _____

FATHER'S NAME _____

MOTHER'S NAME _____

Stepfather _____ Guardian _____

Stepmother _____ Guardian _____

Does Father have legal custody of this child? Y / N

Does Mother have legal custody of this child? Y / N

Address (if different) _____

Address (if different) _____

DOB _____ SS# _____

DOB _____ SS# _____

Hm# _____ Wk# _____

Hm# _____ Wk# _____

Cell# _____ DL# _____

Cell# _____ DL# _____

Employer _____

Employer _____

Person financially responsible _____

INSURANCE INFORMATION

PRIMARY

Policyholder's Name _____

Ins. Co. Name _____

Ins. Address _____

Ins. Phone _____

Group # _____

SECONDARY

Policyholder's Name _____

Ins. Co. Name _____

Ins. Address _____

Ins. Phone _____

Group # _____

GENERAL INFORMATION

Whom may we Thank for referring you? _____

Relative or Friend not living with you:

Name _____ Phone: (____) _____

Address _____

_____ City _____ State _____ Zip _____

MEDICAL HISTORY

Please answer the following. Has your child ever had a history of...

- | | | | |
|-----------------------------|----------------------------------|------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Sickle Cell Disease / Traits | Y N Anemia | Y N Cancer |
| Y N Hemophilia | Y N ADD / ADHD | Y N Asthma | Y N Diabetes |
| Y N Any Operations | Y N Artificial Bones | Y N Convulsions | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Exposed to HIV, but Neg. | Y N Hearing Impairment | Y N Heart Defect |
| Y N Chicken Pox | Y N Hepatitis | Y N Hives | Y N HIV+ / AIDS |
| Y N Epilepsy | Y N Measles | Y N Mononucleosis | Y N Rheumatic / Scarlet Fever |
| Y N Kidney / Liver Problems | Y N Skin Rash | Y N Tuberculosis (TB) | |

Please describe the child's current physical health:

Good Fair Poor

Child's Physician: _____

Phone #: _____ Date of Last Visit _____

Are your child's Immunizations current?

No Yes

Is the child currently under the care of a physician?

Has your child ever seen a cardiologist?

Is your child allergic to any drugs, latex, metals/nickel?

If yes, please list _____

Please list any medical problems that the child has had: _____

Anything you would like to discuss with the Doctor in private?

No Yes

Please list all medications your child is currently taking:

DENTAL HISTORY

Has the child ever had a serious / difficult problem associated with previous dental work?

No Yes

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?

Does the child have any problem brushing?

Does your child have any problem flossing?

Does / did the child have any of the following habits?

N Y Lip Sucking / Biting

N Y Nursing or taking Bottle Habits

N Y Nail Biting

N Y Thumb / Finger Sucking

Why did you bring the child to the dentist today?

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes to my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need to obtain a proper dental evaluation.

Signature

Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments:

MEDICAL HISTORY UPDATE

1. Date: _____ **Signature:** _____
Comments: _____

2. Date: _____ **Signature:** _____
Comments: _____

3. Date: _____ **Signature:** _____
Comments: _____

4. Date: _____ **Signature:** _____
Comments: _____

5. Date: _____ **Signature:** _____
Comments: _____

6. Date: _____ **Signature:** _____
Comments: _____