

WELCOME

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Today's Date _____

Child's Name _____ Birthdate _____ Sex _____

Soc. Sec. # _____ Address _____

Who is responsible for this child Mother Father Other

Responsible party's name _____

Address if different from child _____

Home Phone _____ Work Phone _____

Employer _____ Soc. Sec. # _____

Parent's Marital Status _____

Person to contact in case of emergency _____

Who may we thank for referring you to us _____

Dental Insurance:

Insured's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____ Group # _____

Ins. Co. Address _____

Authorization and Release:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist 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.

Signature of responsible party

Date

ORAL/ MEDICAL HISTORY

1. Have you come to this office for the relief of pain? yes no
If "yes" where is the pain? _____

Have you had pain for more than 3 weeks? yes no

2. Are you happy with the appearance of your smile? yes no

3. Are you interested in changing the appearance of your smile? yes no

4. Are you happy with the color of your teeth? yes no

5. Do you suffer from bad breath or foul taste? yes no

6. Please check any items below that you use often in mouth care:

- | | |
|--|--|
| <input type="checkbox"/> hand toothbrush | <input type="checkbox"/> electric toothbrush |
| <input type="checkbox"/> dental floss | <input type="checkbox"/> gum stimulators |
| <input type="checkbox"/> toothpicks | <input type="checkbox"/> rubber tips |
| <input type="checkbox"/> other | <input type="checkbox"/> water spray |

7. How would you describe your general health?

- poor fair good

Date of last medical examination? _____

8. Are you now being treated or have you been treated within the last year by a physician? yes no

9. Have you ever had an unusual reaction to dental anesthesia (gas or shots)? yes no

10. Following dental treatment, have you had bleeding problems? yes no

11. Do you smoke or use tobacco products? yes no

12. Do you chew ice? yes no

13. Do you grind your teeth? yes no

14. Do you drink:

- | | |
|---------------------------|--|
| Coffee on a daily basis? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Tea on a daily basis? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Soda on a daily basis? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Alcohol on a daily basis? | <input type="checkbox"/> yes <input type="checkbox"/> no |

PLEASE CHECK IF YOU HAVE BEEN TREATED FOR:

- | | |
|--|---|
| <input type="checkbox"/> wisdom teeth | <input type="checkbox"/> TMJ (jaw joint disorder) |
| <input type="checkbox"/> braces, orthodontics | <input type="checkbox"/> dental implants |
| <input type="checkbox"/> periodontal (gum disease) | <input type="checkbox"/> root canals |
| <input type="checkbox"/> crowns, bridges | |

HAVE YOU BECOME SICK FROM OR SHOWN AN ALLERGY TO, OR BEEN TOLD NOT TO TAKE:

15. Antibiotics (Penicillin, etc.) yes no
16. Codeine yes no
17. Novocaine or other dental anesthetic yes no
18. Other drugs or medications _____

19. Do you have any allergies to latex? yes no

ARE YOU NOW TAKING OR USING MEDICINES FOR:

- | | |
|---|--|
| 20. Diabetes (pills or shots) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 21. Nerves (tranquilizers) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 22. Sleeping | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 23. Heart or blood pressure (digitalis, nitroglycerin, reserpine) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 24. Stomach trouble (ulcer or other) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 25. Aspirin, Advil or Motrin | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 26. Arthritis or rheumatism | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 27. Allergy | <input type="checkbox"/> yes <input type="checkbox"/> no |

ARE YOU NOW:

- | | |
|--|--|
| 28. Pregnant | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 29. Breast Feeding | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 30. Using thyroid | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 31. Using hormones (including Birth Control) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 32. Using Anticoagulants, Coumadin | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 33. Using Dilantin | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 34. Please list your medications: _____ | |
| _____ | |
| _____ | |

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- | | |
|--|--|
| 35. Heart Murmur | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 36. Heart Disease | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 37. Heart Attack | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 38. Joint or hip replacement | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 39. Rheumatic Fever | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 40. High blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 41. Fainting spells, seizures, epilepsy | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 42. Glaucoma | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 43. Nervous breakdown, psychotherapy | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 44. Lung trouble (TB, asthma, emphysema) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 45. Hepatitis, liver disease, jaundice | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 46. Arthritis, sore joints, Lupus | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 47. Diabetes | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 48. Excessive bleeding | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 49. Blood trouble, anemia, Leukemia | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 50. VD (syphilis, gonorrhea) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 51. Radiation or Chemotherapy | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 52. Blood transfusion prior to 1985 | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 53. Tested positive for HIV (AIDS) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 54. Use of Prednisone Steroid | <input type="checkbox"/> yes <input type="checkbox"/> no |

Signature _____

Date of Birth _____

Physician's Name _____