Patient Information Form

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Patient Information For Patients Under 18 Years of Age

First Name *

Last Name *

MI

Date of Birth *

mm/dd/yyyy

Address *

City *

State *

Please sel...

Zip Code *

Nickname

Social Security Number

___-__-____

School

Sports/Hobbies

Parent/Guardian Name

Whom may we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

First Name *

Last Name *

MI

Email

Residence

City

State

Please sel...

Zip Code

_____

Mailing Address

City

State

Please sel...

Zip Code

_____

How long at address?

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell/Other Phone

(___) ___-____

Previous Address (if less than 3 years)

City

State

Please sel...

Zip Code

_____

Social Security Number

___-__-____

Relationship to Patient

Date of Birth

mm/dd/yyyy

Employer

Occupation

No. Years Employed

Spouse's Name | Relationship to Patient | Employer | Occupation

No. Years Employed | Social Security Number (___-__-____) | Date of Birth (mm/dd/yyyy) | Work Phone ((___) ___-____)

DENTAL INSURANCE INFORMATION

Insured's Name | Insured's Social Sec # (___-__-____) | Insurance Company | Group No.

Local No. | Insurance Phone No. ((___) ___-____)

Insurance Co. Address | City | State (Please sel...) | Zip Code (_____)

Do you have dual coverage? *

○ Yes ○ No

EMERGENCY INFORMATION

Nearest relative not living with you | Phone ((___) ___-____)

Complete Address | City | State (Please sel...) | Zip Code (_____)

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MEDICAL HISTORY

Physician | Date of Last Visit | Physician Phone

(___) ___-____

Address | City | State | Zip Code

Please sel... | ____

Please check Yes or No (If Yes, please fill in details)

Is the patient taking any medication?
○ Yes ○ No

Is the patient allergic to any medication?
○ Yes ○ No

History of a major illness?
○ Yes ○ No

Has the patient had any operations?
○ Yes ○ No

Ever been involved in a serious accident?
○ Yes ○ No

Have seen a physician in the last 12 months?
○ Yes ○ No

Female Patients only.

Has menstruation started?
○ Yes ○ No

Is the patient pregnant?
○ Yes ○ No

Check any of the medical conditions below that the patient has had or currently has.

- ☐ Abnormal bleeding/Hemophilia
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hayfever
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Kidney problems
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or Cancer

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Are there any medical conditions we have not discussed that you feel we should be aware of?

DENTAL HISTORY

Current Dentist | Date of last visit | What concerns you most about your child's teeth?

Is the patient presently in any dental pain?
○ Yes ○ No

Ever experienced any unfavorable reaction to dentistry?
○ Yes ○ No

Have there been any injuries to face, mouth, or teeth?
○ Yes ○ No

Experienced chronic ear infections?
○ Yes ○ No

Any difficulties with nursing or latching during infancy?
○ Yes ○ No

Any type of thumb or tongue habit?
○ Yes ○ No

Is the patient a mouth breather?
○ Yes ○ No

Has the patient ever seen an orthodontist?
○ Yes ○ No

Aware of clenching or grinding teeth during the day?

Experience sensitivity to texture(s) and/or gets overwhelmed by

Yes No

loud sounds and big crowds?

Yes No

Sensitive stomach, reflux and/or constipation?

Yes No

Does the patient need extra help with instructions?

Yes No

Are you concerned about any delays of your child's development?

Yes No

Is the patient a picky or limited eater?

Yes No

Any sleep disturbance issues such as snoring, constant nighttime awakening, grinding/clenching, and/or excessive daytime sleepiness?

Yes No

Mom's Height

Dad's Height

In order to provide your child with optimum care, we draw upon the knowledge of our entire staff of doctors in consultation, diagnosis and treatment of all patients. The undersigned hereby authorizes this dental office to perform the examination and after explanation, the necessary dental services deemed appropriate for the care of the above named child and furthermore, will be responsible for charges incurred from said dental patient.

Parent Signature *

Today's Date

06/21/2023