Pediatric Dentistry & Family Orthodontics

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Patient Information

Last name_____ First name_____
Physical Address_____ City _____State_____
Zip code_____ Home phone _____Work phone_____
Mailing Address **(If different)** _____
Cell phone _____ DOB _____ SS#_____
E-mail Address_____ Marital status_____
Place of employment_____ Occupation_____
Primary Dental Ins._____ Subscriber#_____
Ins. Address _____
Ins. Phone number _____Group #_____
Insured's name _____SS#_____
DOB_____ Relationship to patient_____

Where would you like your appointment confirmed?
( )home phone ( )work phone ( ) cell phone

Has a member of your family been treated in our office? _____
Whom may we thank for referring you to our office? _____

Primary Reason For This Dental Appointment

____Examination ____ Emergency ____ Consultation

Dental History

1. Do you have a specific dental problem? **Yes/No** If yes, describe_____
   _____
2. Do you have dental examinations on a routine basis? **Yes/No**
3. Do you think you have active decay or gum disease? **Yes/No**
4. Do your gums ever bleed? **Yes/No** If yes, describe_____
   _____
5. Do you brush an floss on a routine basis? **Yes/No**
6. Do you feel nervous about having dental treatment? **Yes/No** If yes, explain _____
   _____
7. Have you ever had a bad experience in a dental office? **Yes/No** If yes, explain _____
   _____
8. Name and address of previous dentist _____
   _____
9. Do you grind your teeth? **Yes/No** If yes, explain _____
10. Do you have TMJ Disorder? **Yes/No**

BUILDING SMILES, FACE & SELF-ESTEEM THE FUN GENTLE & EASY WAY

11. Are you currently under the care of a physician? Yes/No If yes, explain _____
    _____
12. Name of primary care physician. _____
    Name of specialist_____
13. Are you currently taking any medications? **Yes/No** If yes, please list._____
    _____
    _____
    _____
14. Do you have a history of a heart murmur? **Yes/No** If yes, do you require medication prior to dental procedures? **Yes/No**
15. Do you have a history of prolonged bleeding? **Yes/No** If yes, please explain_____
    _____
16. Have you ever had surgery or been hospitalized? **Yes/No** If yes, please explain _____
    _____
17. Please list any allergies to antibiotics, prescription medications or over the counter medications:
    _____
    _____
18. Please list any other allergies such as Latex, pollen, etc._____
    _____
19. Do you require pre-medication prior to dental visits? **Yes/No** If yes, why?_____
    _____
20. Do you have Osteopenia or Osteoporosis? **Yes/No**
    If yes, which one and please list any medications you are taking for it._____
    _____

Please circle if you have any of the following:

ADD/ADHD	Celiac Disease	Excessive Thirst	Hypoglycemia	Scarlet Fever
Acid Reflux	Cerebral Palsy	Fainting/Dizziness	Kidney Trouble	Sinus Trouble
Anemia	Convulsions	Fever Blisters	Lactose Intolerant	Shunt/Stent
Autism	Chemotherapy	Frequent Cough	Liver Disease	Shortness of Breath
Artificial Joints	Chest Pain	Heart Murmur	Lung Disease	Stroke
Arthritis	Diabetes	Heart Trouble	Pain in Jaw Joints	Swelling of Feet/Ankles/Hands
Artificial Heart Valve	Disabilities	Hemophilia	Pacemaker	TIA
Behavior Problems	Down Syndrome	Hepatitis A, B, or C	Parathyroid Disease	Tuberculosis
Bi-Polar Disorder	Drug Addiction	Herpes	Psychiatric Care	Thyroid Disease
Blood Transfusions	Epilepsy	High Blood Pressure	Rheumatic Fever	Ulcer
Cancer	Emphysema	HIV/AIDS	Rheumatism	Venereal Disease

Please list any conditions you have that are not mentioned above.
_____
_____
_____
_____

Emergency Contact

Name _____ Phone _____
Address _____

Account Information

I am aware that payment is expected at the time of service and agree to pay Pediatric Dentistry & Family Orthodontics in full, at that time services are rendered, unless a prior arrangement has been worked out with our Business Staff.

_____ Date _____
(Signature of patient, if a minor than signature of parent or guardian of patient)