



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 and 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.

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