PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

PARENT'S NAME _____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

DENTAL HISTORY

1. Is this the child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? _____
3. Does the child eat between meals? ..... YES NO
4. Does the child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
5. Does the child eat well balanced meals? ..... YES NO
6. Does the child brush teeth upon arising? ..... YES NO
   when going to bed? ..... YES NO
   right after eating meals? ..... YES NO
   after eating any food? ..... YES NO
7. Do you live in an area with fluoridated water? ..... YES NO
8. Have teeth been treated with fluorides? ..... YES NO
9. Have cavities been noted in the past? ..... YES NO
10. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
    Was it suggested that the space be maintained? ..... YES NO
    Was appliance placed? ..... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips etc.? ..... YES NO
    If so, describe _____
12. Has the child had any unfavorable dental experiences? ..... YES NO
13. How many children in your family? _____
14. Has anyone in the family, including parents, had orthodontics? ..... YES NO
15. Has child ever received local anesthetic? ..... YES NO
16. Has child ever had occlusal sealants? ..... YES NO

MEDICAL HISTORY

1. Is child in good health? ..... YES NO
2. Is child under care of a physician? ..... YES NO
   If yes, since when and why _____
3. Name of physician _____
4. Has the child had any serious illness? ..... YES NO
   When _____ What was the illness _____
5. Has the child had surgery? ..... YES NO
6. Is surgery contemplated? ..... YES NO
7. Is the child prone to profuse bleeding? ..... YES NO
8. Is the child subject to nervous disorders? ..... YES NO
   fainting? ..... YES NO
   dizziness? ..... YES NO
9. Does the child have allergies? ..... YES NO
10. Is the child allergic to penicillin, antibiotics or other drugs? ..... YES NO
11. Is the child receiving any medication? ..... YES NO
    What? _____
12. Has the child had history of: *(circle appropriate response.)* Diabetes, Heart Trouble, Asthma Kidney Infection, Rheumatic Fever, Toothache, Ear Infection.

I CERTIFY THAT THE ABOVE IS COMPLETE AND ACCURATE

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. 131CDM

CHILD DENTAL MEDICAL HISTORY

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESS _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT: Check ☐ Credit Card ☐ Cash ☐

DRIVER'S LICENSE #: _____

STATE ISSUED: _____

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL _____

_____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

_____

Date _____ Date of Birth _____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION