

Date \_\_\_\_\_ Child \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Birthdate \_\_\_\_\_

Person Financially Responsible \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Parents' Marital Status      Single      Married      Divorced      Separated

Father \_\_\_\_\_ Mother \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employed By \_\_\_\_\_ Employed By \_\_\_\_\_

Work Address \_\_\_\_\_ Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_ ext \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ Dental Insurance Carrier \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Group Number \_\_\_\_\_ Group Number \_\_\_\_\_

Social Security Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

If alternate insurance applies or if you have a Flex Spending Account, please advise.

Family Dentist \_\_\_\_\_ Date of last Dental Exam \_\_\_\_\_

Have we treated other members of your family? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_



**Please answer the following questions about the patient being examined.  
Please check "Yes" or "No"**

		Yes	No
1.	Family Physician _____		
2.	Are you under the care of a physician at the present time? If so, for what? _____		
3.	Have you been told that you have a heart condition (Angina Pectoris, Mitral Valve Prolapse, Heart Attack, etc.) _____		
4.	Have you been told that your blood pressure is too high or too low? _____		
5.	Do you have any prosthetic heart valves or joints? _____		
6.	Have you ever had rheumatic heart disease or rheumatic fever? _____		
7.	Do you bleed abnormally following a cut or injury? _____		
8.	Are you allergic to any food, drug or medicine (or latex)? If so, what? _____		
9.	Do you have other allergies such as hay fever or asthma? _____		
10.	Do you have any lung problems (Tuberculosis, emphysema, etc.?) _____		
11.	Are you taking any pills or drugs at the present time? If so, for what? _____		
12.	Do you have a history of diabetes or hypoglycemia? _____		
13.	Have you ever been treated for epilepsy? _____		
14.	Women, are you pregnant? _____		
15.	Have you noticed any spurting in height recently? _____		
16.	Have you ever taken Cortisone, steroids, or similar drugs? _____		
17.	Have you ever been treated for an emotional disturbance? _____		
18.	Do you have a history of hepatitis, jaundice or any liver disease? _____		
19.	Have you had a bone disease? _____		
20.	Have you ever had a tumor or cancer? _____		
21.	Have you ever had x-ray treatments for tumors or cancer? _____		
22.	Have you ever had an operation? If so, for what? _____		
23.	Do you still have your tonsils or adenoids? _____		
24.	Have you ever had a disease of the eyes, ears, nose or throat? _____		
25.	Do you, or did you ever, suck your thumb or fingers? If so, until what age? _____		
26.	Do you, or did you ever, have any other oral habits? _____		
27.	Have you ever had any accidents to your head, face or teeth? If so, please explain. _____		
28.	Have you had any serious illnesses other than those above? If so, please explain. _____		
29.	Do you have AIDS or any other immunosuppressive disorders? _____		
30.	Have you ever had any TMJ (jaw) problems? _____		
31.	Have you ever had any kind of orthodontic treatment? _____		

**Parent's Signature**

**Date**