1000 North Fielder Road, Arlington TX 76012

Today's Date _____

1. About Your Child

Child's Name _____
(Last) (First) (MI)

Goes By: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School _____ Grade _____

Child's Primary # (____) _____

SS # _____

Child's Home Address _____
(Street)

_____
(City) (State) (Zip)

Child's Race _____ Languoge(s) spoken _____

Pets and Hobbies _____

2. How did you hear about our office?

☐ Patient ☐ Doctor ☐ Other

Name _____

3. Mother's Information

Name _____

☐ Mother ☐ Stepmother ☐ Guardian Birthdate ____/____/____

Employer _____

Occupation _____

Work # (____) _____

Home # (____) _____

Cellular # (____) _____

SS# _____ DL # _____

E-mail _____

4. Father's Information

Name _____

☐ Father ☐ Stepfather ☐ Guardian Birthdate ____/____/____

Employer _____

Occupation _____

Work # (____) _____

Home # (____) _____

Cellular # (____) _____

SS# _____ DL # _____

E-mail _____

5. Who is Accompanying your Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account/Payment

Name _____

Relationship _____

Billing Address _____
(Street)

_____
(City) (State) (Zip)

Work # (____) _____

Home # (____) _____

Cellular # (____) _____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____
(Street)

_____
(City) (State) (Zip)

Ins. Co. Ph # (____) _____

Group # (Plan, Local, or Policy#) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

SS # _____

Policy Owner's Employer _____

8. Other Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____
(Street)

_____
(City) (State) (Zip)

Ins. Co. Ph# (____) _____

Group # (Plan, Local, or Policy#) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

SS# _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

How long since the last visit to the dentist? _____

Previous dentist's name _____

Were any x-rays taken during the previous dental visit? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

Why did you bring the child to the dentist today? _____

_____

Does the child have any of the following habits?

☐ Y	☐ N	Lip sucking or biting	☐ Y	☐ N	Nail biting
☐ Y	☐ N	Nursing or bottle habits	☐ Y	☐ N	Thumb or finger sucking
☐ Y	☐ N	Grinding teeth	☐ Y	☐ N	Pacifier use

Has the child ever had a serious or difficult problem associated with previous dental work?

If yes, please explain _____

_____

How would you rate your childs attitude toward medical/dental visits?

☐ Good ☐ Anxious ☐ Definitely negative

Is the child's water fluoridated?	☐ Y	☐ N	☐ Not Sure
Is the child taking fluoride supplements?	☐ Y	☐ N	☐ Not Sure
Has the child ever had any pain or tenderness in his/her jaw/joint?	☐ Y	☐ N	☐ Not Sure
Does the child brush his/her teeth daily?	☐ Y	☐ N	☐ Not Sure
Does the child floss daily?	☐ Y	☐ N	☐ Not Sure

10. Health History

Has the child ever had any of the following conditions?

☐ Y	☐ N	Heart Disease/Murmur/Defect	☐ Y	☐ N	Physical disabilities
☐ Y	☐ N	Hemophilia/Blood Disorders	☐ Y	☐ N	Mental disabilities
☐ Y	☐ N	Kidney/Liver Conditions	☐ Y	☐ N	Eye problems
☐ Y	☐ N	Diabetes	☐ Y	☐ N	Hearing impairment
☐ Y	☐ N	Seizures/Epilepsy	☐ Y	☐ N	Drug Allergies
☐ Y	☐ N	Congenital Birth Defects	☐ Y	☐ N	Food, metal, dye allergies
☐ Y	☐ N	Cancer	☐ Y	☐ N	Latex Allergies
☐ Y	☐ N	Tuberculosis	☐ Y	☐ N	Sinus Allergies
☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Asthma
☐ Y	☐ N	HIV+ / AIDS	☐ Y	☐ N	Autism
☐ Y	☐ N	Shunts	☐ Y	☐ N	Speech problems/delay
☐ Y	☐ N	Any hospital stays	☐ Y	☐ N	Sensory disorder/PDD
☐ Y	☐ N	Any operations	☐ Y	☐ N	ADD/ADHD
☐ Y	☐ N	Pregnancy			

If answered yes, please explain: _____

_____

Does your child have difficulty with any of the following:

☐ Concentrating ☐ Learning ☐ Cooperating ☐ Understanding

Any condition that was not explained above:

_____

_____

Are the childs immunizations up-to-date? ☐ Y ☐ N

Please list all drugs the child is currently taking: _____

_____

Is the child currently under the care of a physician? ☐ Y ☐ N

Child's physician: _____

phone# (_____) _____

Is there anything else you would like us to know about your child? _____

_____

11. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date

For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient name herein

Initials _____ Date _____

Doctor's comments: _____

_____

_____

_____