

TOTAL DENTAL CARE

of Middle Island

PATIENT INFORMATION (CHILD)

Date _____

Child's Name _____

Date of Birth _____ Age _____
Sex: Male Female

School _____ Grade _____

Child's Favorite Interest/Hobby _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Who is Responsible for this account? _____

Relationship to Patient _____

Responsible Party's SS# (required) _____

Mother's Name _____

Mother's Occupation _____

Mother's Employer _____ *Phone* _____

Employer's Address _____

Mother's Cell Phone _____

Father's Name _____

Father's Occupation _____

Father's Employer _____ *Phone* _____

Employer's Address _____

Father's Cell Phone _____

INSURANCE INFORMATION:

Dental Insurance (Primary) _____

Subscriber's Name _____

Subscriber's SS# or ID# _____

Group# _____

Dental Insurance (Secondary) _____

Subscriber's Name _____

Subscriber's SS# or ID # _____

Group# _____

Email Address (Parent/Guardian) _____

Whom may we thank for referring you? _____

Have you seen/heard any of our advertising?
 Newspaper Movie Theater Mailings Website
 Radio If yes, what radio station? _____

DENTAL INFORMATION:

Is this your child's first dental visit? YES NO
Date of last visit _____

Present dental problem as you see it (if any) _____

Does your child brush daily? YES NO
If yes, when? _____

Does an adult assist with brushing? YES NO
What toothpaste does your child use _____

Has your child ever had xrays taken? YES NO

Has your child ever had Novocaine? YES NO
If yes, by which doctor? _____

Were there any complications? _____

Does your child have any of the following bad habits:
 use of bottle pacifier nail biting
 finger sucking thumb sucking tongue thrusting
 mouth breathing tooth grinding

Does your child receive fluoride in any of the following forms:

water supply toothpaste mouthwash/rinse
 vitamins
Vitamin Name/Dosage _____

How has your child reacted to previous dental visits? _____

How do you expect your child to react today?
 excellent good fair poor
 don't know

MEDICAL HISTORY: CERTAIN ILLNESSES OR DRUGS MAY MAKE IT NECESSARY TO ALTER OUR TREATMENT IN OUR ENDEAVOR TO RENDER THE BEST POSSIBLE ORAL HEALTH CARE TO YOUR CHILD. IT IS NECESSARY TO HAVE THE FOLLOWING INFORMATION.

Child's Pediatrician _____

Address _____

City _____ State _____ Zip _____

Phone _____

Date of child's last physical and reason _____

HAVE YOU EVER OR NOW HAVE (PLEASE CHECK YES OR NO):

- | Y | N | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | ALLERGIES TO MEDICINE |
| <input type="checkbox"/> | <input type="checkbox"/> | ANEMIA |
| <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA |
| <input type="checkbox"/> | <input type="checkbox"/> | AUTISM |
| <input type="checkbox"/> | <input type="checkbox"/> | BLADDER CONDITIONS |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD TRANSFUSIONS |
| <input type="checkbox"/> | <input type="checkbox"/> | BIRTH DEFECTS |
| <input type="checkbox"/> | <input type="checkbox"/> | BONE OR JOINT PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | BRAIN INJURY |
| <input type="checkbox"/> | <input type="checkbox"/> | BRUISING EASILY |
| <input type="checkbox"/> | <input type="checkbox"/> | CANCER OR MALIGNANCIES |
| <input type="checkbox"/> | <input type="checkbox"/> | CEREBRAL PALSY |
| <input type="checkbox"/> | <input type="checkbox"/> | CHILD ABUSE |
| <input type="checkbox"/> | <input type="checkbox"/> | CHRONIC ADNOID/TONSIL INFECTION |
| <input type="checkbox"/> | <input type="checkbox"/> | CHRONIC HEADACHES |
| <input type="checkbox"/> | <input type="checkbox"/> | CHRONIC EAR INFECTION |
| <input type="checkbox"/> | <input type="checkbox"/> | CLEFT PALATE/LIP |
| <input type="checkbox"/> | <input type="checkbox"/> | CONVULSIONS/SEIZURES |
| <input type="checkbox"/> | <input type="checkbox"/> | DEVELOPMENTAL DELAY |
| <input type="checkbox"/> | <input type="checkbox"/> | DIABETES |
| <input type="checkbox"/> | <input type="checkbox"/> | DRUG/ALCOHOL ABUSE |
| <input type="checkbox"/> | <input type="checkbox"/> | EMOTIONAL DISTURBANCE |
| <input type="checkbox"/> | <input type="checkbox"/> | EPILEPSY |
| <input type="checkbox"/> | <input type="checkbox"/> | EYE PROBLEM |
| <input type="checkbox"/> | <input type="checkbox"/> | EXCESSIVE BLEEDING |
| <input type="checkbox"/> | <input type="checkbox"/> | EXCESSIVE GAGGING |
| <input type="checkbox"/> | <input type="checkbox"/> | FAINING OR DIZZINESS |
| <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT INFECTIONS |
| <input type="checkbox"/> | <input type="checkbox"/> | GROWTH AND DEVELOPMENTAL PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING/SPEECH PROBLEM |
| <input type="checkbox"/> | <input type="checkbox"/> | HEART MURMUR/DEFECT |
| <input type="checkbox"/> | <input type="checkbox"/> | HEMOPHELIA |
| <input type="checkbox"/> | <input type="checkbox"/> | HEPATITIS/LIVER DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | HYPERACTIVITY |
| <input type="checkbox"/> | <input type="checkbox"/> | JAUNDICE |
| <input type="checkbox"/> | <input type="checkbox"/> | MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> | <input type="checkbox"/> | PIN/JOINT REPLACEMENTS |
| <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | LEUKEMIA |
| <input type="checkbox"/> | <input type="checkbox"/> | MENTAL RETARDATION |
| <input type="checkbox"/> | <input type="checkbox"/> | NUTRITIONAL/EATING DISORDER |
| <input type="checkbox"/> | <input type="checkbox"/> | ORAL ULCERS |
| <input type="checkbox"/> | <input type="checkbox"/> | ORTHOPEDIC PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | PNEUMONIA |
| <input type="checkbox"/> | <input type="checkbox"/> | PREMATURE BIRTH |
| <input type="checkbox"/> | <input type="checkbox"/> | RHEUMATIC FEVER |
| <input type="checkbox"/> | <input type="checkbox"/> | SCOLIOSIS |
| <input type="checkbox"/> | <input type="checkbox"/> | SICKLE CELL ENEMIA |
| <input type="checkbox"/> | <input type="checkbox"/> | SINUS PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | SORE THROAT (FREQUENT) |
| <input type="checkbox"/> | <input type="checkbox"/> | SPINA BIFIDA |
| <input type="checkbox"/> | <input type="checkbox"/> | SYNDROME/TYPE |
| <input type="checkbox"/> | <input type="checkbox"/> | TUBERCULOSIS |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER |

Is your child in good health?

YES NO

Are your child's immunizations up to date?

YES NO

Is your child being treated for any condition presently?

YES NO If so, explain, _____

Is your child taking any medication (including vitamins)?

YES NO If so, explain _____

Has your child ever been hospitalized/had general anesthesia or sedation?

YES NO

Does your child have any allergies or reactions to medications?

YES NO If so, explain _____

Does your child have any allergies to the following:

Pollen Dust Food Food Dyes Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been covered _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/ALL NECESSARY SERVICES CAN BE PERFORMED. I ACKNOWLEDGE THAT THE INFORMATION ABOVE AND ON THE OTHER SIDE IS CORRECT. I AUTHORIZE THE DOCTOR TO TAKE XRAYS, PHOTOGRAPHS, OR OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS AND GRANT THIS OFFICE TO PROVIDE MY CHILD'S DENTAL TREATMENT. THIS CONSENT IS ALSO VALID FOR EMERGENCY DENTAL TREATMENT. IF NECESSARY, EVEN IN MY ABSENCE. FURTHERMORE, I UNDERSTAND THAT IF MY INSURANCE DOES NOT COVER THE COST OF THIS DENTAL CARE, I WILL BECOME FINANCIALLY RESPONSIBLE FOR IT.

SIGNATURE OF PARENT/GUARDIAN

DATE

RELATIONSHIP TO CHILD

WITNESS

DOCTOR'S SIGNATURE

UPDATES

Has there been any changes in your health since your last dental appointment?

YES NO _____
PARENT/GUARDIAN DATE

DOCTOR DATE

YES NO _____
PARENT/GUARDIAN DATE

DOCTOR DATE