Thank you for taking the time to complete these forms.

PATIENT'S NAME: FIRST	LAST	MIDDLE	PREFERRED NAME (OPTIONAL)
BIRTHDATE (mm/dd/yyyy)	GENDER ◯ MALE ◯ FEMALE	HOME ADDRESS (Number, Street, Route, Etc.)	

CITY	STATE	ZIP	HOME PHONE (XXX-XXX-XXXX)	CELL PHONE (XXX-XXX-XXXX)	OTHER PHONE (XXX-XXX-XXXX)

EMAIL ADDRESS (EXAMPLE@DOMAIN.COM):

MARTIAL STATUS OF PARENTS (Check one) ◯ MARRIED ◯ SINGLE ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED ◯ PARTNER

WITH WHOM DOES PATIENT LIVE?	WHO DO WE CONTACT TO SCHEDULE AND INFORM?

Please provide the following information if the patient is under 18 years of age or has a legal guardian

Person responsible for payment of services?:

Relationship to patient:

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
MAILING ADDRESS (if different from patient)	CITY	STATE	ZIP
Employer	Present Position	Work # is it OK to call your work? ◯ Yes ◯ No	

Other Parent/Guardian

Relationship to patient:

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
MAILING ADDRESS (if different from patient)	CITY	STATE	ZIP
Employer	Present Position	Work # is it OK to call your work? ◯ Yes ◯ No	

Primary Dental Insurance:

POLICY HOLDER: FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
Employer:	Group Number	Insurance Company	
Dental Insurance Address (Primary)	CITY	STATE	ZIP
INSURANCE PHONE NUMBER (XXX-XXX-XXXX)			

Secondary Dental Insurance:

POLICY HOLDER: FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
Employer:	Group Number	Insurance Company	
Dental Insurance Address (Primary)	CITY	STATE	ZIP
INSURANCE PHONE NUMBER (XXX-XXX-XXXX)			

Who can we thank for referring you to our practice?	Name

EMERGENCY CONTACT: FIRST NAME	LAST	PHONE NUMBER	RELATIONSHIP TO PATIENT

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 health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill or services. I understand that I am financially responsible for payment 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 payer. I attest to the accuracy of the information on this page.

Signature:	Date:

Pediatric Medical and Dental History

PATIENT'S FULL NAME				PREFERRED NAME (OPTIONAL)	BIRTHDATE (mm/dd/yyyy)
GENDER ◯ MALE ◯ FEMALE	Race/Ethnicity	HEIGHT	WEIGHT	NAME OF PERSON FILLING OUT THIS FORM	RELATIONSHIP TO PATIENT

NAME OF PRIMARY CARE PHYSICIAN	PHYSICAN PHONE (xxx-xxx-xxxx)	NAME OF MEDICAL SPECIALIST (IF APPLICABLE)	SPECIALIST PHONE

Is your child being treated by a physician at this time? If yes please explain:	◯ YES	◯ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? If yes please list name, dose, & date started:	◯ YES	◯ NO
Has your child ever been hospitalized, had surgery or a significant injury? If yes please list year and describe:	◯ YES	◯ NO
Has your child ever had a reaction to or problem with an anesthetic? Describe:	◯ YES	◯ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? If yes please list and describe:	◯ YES	◯ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List:	◯ YES	◯ NO
Is your child up to date on immunizations against childhood diseases?	◯ YES	◯ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of the list. Mark NO after each line if none of these conditions apply to your child.

Complications before or during birth, prematurity, birth defects, syndromes or inherited conditions	◯ YES	◯ NO
Problems with physical growth or development	◯ YES	◯ NO
Sinusitis, chronic adenoid/tonsil infections	◯ YES	◯ NO
Sleep apnea/snorting, mouth breathing, or excessive gagging	◯ YES	◯ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	◯ YES	◯ NO
Irregular heart beat or high blood pressure	◯ YES	◯ NO
Asthma, reactive airway disease, wheezing, or breathing problems	◯ YES	◯ NO
Cystic fibrosis	◯ YES	◯ NO
Frequent colds or coughs, or pneumonia	◯ YES	◯ NO
Frequent exposure to tobacco smoke	◯ YES	◯ NO
Gastrointestinal problems such as jaundice, hepatitis, liver problems, acid reflux disease, etc.	◯ YES	◯ NO
Lactose intolerance, nutrutional deficiencies, dietary restrictions, concerns with weight or eating disorder	◯ YES	◯ NO
Food allergies. If YES, list:	◯ YES	◯ NO
Bladder or kidney problems	◯ YES	◯ NO
Arthritis, scoliosis, limisted use of arms or legs, or muscle/bone/joint problems	◯ YES	◯ NO
Rash/hives, eczema or skin problems	◯ YES	◯ NO
Impaired vision, hearing, or speech	◯ YES	◯ NO
Developmental disorders, learning problems/delays, or intellectual disability	◯ YES	◯ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures	◯ YES	◯ NO
Autism/autism spectrum disorder	◯ YES	◯ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	◯ YES	◯ NO
Hydrocephaly or placement of shunt	◯ YES	◯ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	◯ YES	◯ NO
Behavioral, emotional, communications, or psychiatric problems/treatment	◯ YES	◯ NO
Abuse (physical, psychological, emotional, or sexual) or neglect	◯ YES	◯ NO
Diabetes, hyperglycemia, hypoglycemia, precocious puberty, hormone problems, thyroid or pituitary problems	◯ YES	◯ NO
Blood disorders such as; anemia, sickle cell, hemophilia, excessive bleeding, blood transfusions	◯ YES	◯ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow/organ transplant	◯ YES	◯ NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphlococcus aureus (MRSA), sexually transmitted infections (STI), or human immunodeficiency virus (HIV)/AIDS	◯ YES	◯ NO

PROVIDE DETAILS HERE:

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? If yes please explain:	◯ YES	◯ NO

Pediatric Medical and Dental History Page 2

What is your primary concerns or thoughts about your child's oral health? Describe:

How would you describe:

your child's oral health?	Excellent	Good	Fair	Poor
your oral health?	Excellent	Good	Fair	Poor
oral health of your other children?	Excellent	Good	Fair	Poor

Is there a family history of cavities? YES NO If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	YES	NO	
Mouth sores or fever blisters	YES	NO	
Bad Breath	YES	NO	
Bleeding gums	YES	NO	
Cavities/decayed teeth	YES	NO	
Toothache	YES	NO	
Injury to teeth, mouth or jaws	YES	NO	
Clinching/grinding her/her teeth	YES	NO	
Jaw joint problems (popping, etc)	YES	NO	
Excessive gagging	YES	NO	
Sucking habit after one year of age	YES	NO	If yes, which: Finger Thumb Pacifier Other For how long?

How often does your child brush his/her teeth? times per Does someone help your child brush? YES NO

How often does your child floss his/her teeth? Never Sometimes Daily Does someone help your child floss? YES NO

What type of toothbrush does your child use? Hard Medium Soft Unsure

What toothpaste does your child use?: Do you use a water filter at home? YES NO

What is the source of your drinking water at home? City/community supply Private well Bottled water Other

Please check all sources of fluoride you child receives:

Drinking Water Toothpaste Over-the-counter rinse Prescription rinse/gel Prescription drops/tablets/vitamins

Fluoride treatment in the dental office Fluoride varnish by pediatrician/other practitioner Other:

For each YES response, please describe:

Does your child regularly eat 3 meals each day?			YES NO
Is your child on a special or restricted diet?	YES	NO	
Is your child a 'picky eater'?	YES	NO	
Does your child have a diet high in sugars or starches?	YES	NO	
Do you have any concerns regarding your child's weight?	YES	NO	

How frequently does your child have the following?

Candy or other sweets	Rarely	1-2 times/day	3 or more times/day	**Product:**
Chewing gum	Rarely	1-2 times/day	3 or more times/day	**Type:**
Snacks between meals	Rarely	1-2 times/day	3 or more times/day	**Usual Snack:**
Soft drinks*	Rarely	1-2 times/day	3 or more times/day	**Product:**

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits:

Does your child participate in any sports	YES	NO	If YES, list:
Does your child wear a mouthguard during these activities?	YES	NO	If YES, What Type:

Has your child been examined or treated by another dentist? YES NO

If YES: Date of first visit: Date of last visit: Reason for last visit:

Were x-rays taken of the teeth or jaw?	YES	NO	Date of most recent dental x-rays:
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?	YES	NO	If YES, when?
Has your child ever had a difficult dental appointment?	YES	NO	If YES, describe?
How do you expect your child will respond to dental treatment?	Very well	Fairly well	Somewhat poorly Very poorly
Is there anything else we should know before treating your child?	YES	NO	If YES, describe?

SIGNATURE:	DATE	RELATIONSHIP TO PATIENT

Pediatric Medical and Dental History Supplemental

QUESTIONS FOR AN INFANT/TODDLER (1-3 YEARS OR AGE)

Was your child born prematurely?	○ YES	○ NO	If YES, what week?			
What was your child's birth weight? LB OZ			Child's age (in months) when first tooth appeared in mouth:			
How long was your child breast-fed?	○ N/A	○ Less than 6 months	○ 6-11 months	○ 12-17 months	○ 18-23 months	○ 2 years or more
How long was your child bottle-fed?	○ N/A	○ Less than 6 months	○ 6-11 months	○ 12-17 months	○ 18-23 months	○ 2 years or more
Inherited dental characteristics	○ YES	○ NO	If YES, What type (check one)	○ Ready to use	○ Powdered	○ Liquid Concentrate
Does/did your child sleep with a bottle?	○ YES	○ NO	If YES, content of bottle?			
Does/did your child use a no-spill training cup (sippy cup)?	○ YES	○ NO	Has your child experienced any teething problems?	○ YES	○ NO	
When did you start brushing his/her teeth?	○ N/A	○ Before 6 months	○ 6-11 months	○ 12-17 months	○ 18-23 months	○ 2 years or more
When did you begin using toothpaste?	○ N/A	○ Before 6 months	○ 6-11 months	○ 12-17 months	○ 18-23 months	○ 2 years or more
Who is your child's primary care taker during the day?			Who is your child's primary care taker during the evening?			
Name/Age of siblings at home:						
SIGNATURE:			DATE		RELATIONSHIP TO PATIENT	

QUESTIONS FOR AN ADOLESCENT PATIENT (TO BE COMPLETED BY THE PATIENT) (Ages 13 and Up)

Do you have any concerns about your mouth, teeth, or oral health?	○ YES	○ NO	If YES, Describe?
Have you recently experienced any dental/oral pain?	○ YES	○ NO	If YES, Describe?
Do you bleach your teeth?	○ YES	○ NO	If YES, how often?
Have there been any recent changes in your dietary habits?	○ YES	○ NO	If YES, Describe?
Are you taking any dietary or herbal supplements?	○ YES	○ NO	If YES, Describe?
Do you participate in contact sports or high speed sports (skiing, motorcycles)?	○ YES	○ NO	If YES, Describe?

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.)	○ YES	○ NO	○ PREFER NOT TO ANSWER
Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)	○ YES	○ NO	○ PREFER NOT TO ANSWER
Eating disorder (anorexia, bulimia, etc.)	○ YES	○ NO	○ PREFER NOT TO ANSWER
Oral piercings/jewelry (including grill)	○ YES	○ NO	○ PREFER NOT TO ANSWER
Alcohol or recreational drug use/prescription abuse	○ YES	○ NO	○ PREFER NOT TO ANSWER
Inhalant use/abuse (such as huffing)	○ YES	○ NO	○ PREFER NOT TO ANSWER
Females: Are you pregnant or possibly pregnant?	○ YES	○ NO	
Is there anything you would like to discuss confidentially with your dentist?	○ YES	○ NO	
Would you like to discuss a referral to a family dentist or general dentist because of your age?	○ YES	○ NO	