



Patient Information

Date _____

*****Please Provide Information for the Patient to be Seen**

Patient Name _____ DOB _____ Age _____

Nickname _____ Social Security Number _____ Gender Male Female

Address _____ City _____ Zip Code _____

Phone: home _____ cell _____ work _____

Patient (or parent) email _____

What is the reason for your visit today _____

How did you hear about this office _____

*****Please Provide Information for the Person who is insured and the Insurance Company**

Name of Insured _____ DOB _____

Employer _____ SS# _____

Insurance Carrier Name _____

Group # _____ Policy# _____

Address _____

Phone Number _____

*****Please Provide the following information if the patient is a child under 18 years old**

School/Daycare _____ Grade _____

Mom – Name _____

Cell Phone _____

Work Phone _____

Employer _____

Dad – Name _____

Cell Phone _____

Work Phone _____

Employer _____

Who brought the patient in today _____ Relationship to patient _____

Do you have legal custody Yes No (if not, then who does _____)

Health History

*****Please Provide Information for the Patient to be Seen**

- Yes No - Currently in good health?
 Yes No - Previous health problems? Explain _____
 Yes No - Ever been hospitalized? Explain _____
 Yes No - Food or medicine allergies? List _____
 Yes No - Currently taking any medications? List _____

Please check any item that the patient been diagnosed/treated/observed for:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Bleeding/transfusions |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Liver/GI Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asperger's | <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Speech/hearing |
| <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays | <input type="checkbox"/> Eyes/vision |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Ear infections/tubes |

Dental History

- Yes No - Has the patient ever been to the dentist? If yes, name of dentist _____
- Date of last dental visit and x-rays _____
 Yes No - Any previous bad experience with a dentist? Explain _____
 Yes No - Any concerns about TMJ (pain/sounds)? Explain _____
 Yes No - Any previous injury/trauma? Explain _____
 Yes No - Any concerns about teeth appearance/color? Explain _____
 Yes No - Concerns about cavities, pain, infection? Explain _____

Other concerns _____

*****Please Provide the following information if the patient is a child under 18 years old**

Name of child's physician _____ Office location _____ Date of last exam _____

- Yes No - Does your child suck a finger, thumb or pacifier? Explain _____
 Yes No Unknown - Is your home water supply fluoridated?
 Yes No Unknown - Does your child use fluoride toothpaste?
 Yes No Unknown - Does your child participate in a school fluoride rinse program?
 Yes No - Were there any problems at birth? Explain _____

Do you consider your child's development and learning to be: Advanced Normal Slow

*****Please provide signature of the person filling out the above information, acknowledging that the above information is accurate to the best of their knowledge.**

Name _____ Signature _____ Date _____

Doctor's note only: