## PATIENT INFORMATION

PATIENT'S NAME: ____________________

NICKNAME: ____________________

HOME PHONE: ____________________

DATE OF BIRTH: ____________ AGE: ______

SCHOOL: ____________ GRADE: ______

HOBBIES/SPORTS: ____________________

____________________

**PATIENT'S HOME ADDRESS:**

STREET: ____________________

CITY & ZIP: ____________________

BROTHERS/SISTERS & AGES: ____________________

____________________

PATIENT'S PHYSICIAN: ____________________

PATIENT'S DENTIST: ____________________

REFERRED BY: ____________________

## PARENT INFORMATION

MOTHER/GUARDIAN NAME: ____________________

HOME ADDRESS: ____________________

____________________

EMPLOYMENT/OCCUPATION: ____________________

CELL PHONE: ____________________

FATHER/GUARDIAN NAME: ____________________

HOME ADDRESS: ____________________

____________________

EMPLOYMENT/OCCUPATION: ____________________

CELL PHONE: ____________________

PREFERRED EMAIL: (CIRCLE ONE)

MOTHER FATHER GUARDIAN

EMAIL: ____________________

PARENT'S MARITAL STATUS: ____________________

WHO DOES PATIENT LIVE WITH: ____________________

**MEDICAL INFORMATION:** (PLEASE CIRCLE ALL THAT APPLY)

| | | | |
|---|---|---|---|
| HIV POSTITIVE OR AIDS | | CONGENITAL HEART DEFECT | ADD/ADHD |
| DIABETES | EPILEPSY | HANDICAPS OR DISABILITIES | HEART MURMUR |
| RHEUMATIC FEVER | ABNORMAL BLEEDING | HEPATITIS | SURGERIES |
| HEARING PROBLEMS | TUBERCULOSIS | ASTHMA | VENEREAL DISEASE |
| KIDNEY/LIVER PROBLEMS | CANCER | HEADACHES | NERVOUS PROBLEMS |

**ALLERGIES:** (PLEASE CIRCLE ALL THAT APPLY)

ALLERGIES TO FOOD ALLERGIES TO MEDICINE ALLERGIES TO LATEX ALLERGIES TO METAL

PLEASE EXPLAIN KNOWN ALLERGIES: ____________________

IS THE PATIENT CURRENTLY TAKING ANY MEDICATION? ____________________

**DENTAL INFORMATION: (CIRCLE)**
**HAS THE PATIENT EVER HAD:**

PREVIOUS OTHODONTIC TREATMENT
FILLINGS
SEALANTS
DENTAL TRAUMA

**DATE OF LAST DENTAL VISIT:** ____________________
**IS THERE A HISTORY OF?**

| | |
|---|---|
| THUMB OR FINGER SUCKING | GRINDING OR CLENCHING OF TEETH |
| SNORING | EXTRA OR MISSING TEETH |
| SPEECH THERAPY | TEETH REMOVED BY DENTIST |
| JAW PAIN | |

PLEASE LET US KNOW IF THERE IS ANY OTHER INFORMATION (HEALTH OR OTHERWISE) THAT YOU FEEL IS IMPORTANT SO THAT YOUR CHILD IS COMFORTABLE IN OUR OFFICE.____________________

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

SIGNATURE OF PARENT OR GUARDIAN: ____________________ DATE: ______