Patient Information

Child's Name:_____ **Age**:_____ **Birth Date**: _____

Last Name First Name Middle Initial

Gender: **Male Female** **E-mail address**:_____ **Referred By**: _____

Home Address:

_____

Street City/State Zip Code

Home #_____**Mom's Cell#** _____**Dad's Cell #**_____

Parents Martial Status: **Married Divorced Single Widowed**

Mother Stepmother Grandmother **Birth Date**: _____

Name: _____ **Social Security Number:**_____

Address: _____

Street City/State Zip Code

Employer: _____ **Work Number**: _____

Father Stepfather Grandfather **Birth Date:** _____

Name: _____ **Social Security Number:** _____

Address:

_____

Street City/State Zip Code

Employer: _____ **Work Number:** _____

Dental Insurance

Primary Insurance Company Name: _____ **Group Number**:_____

Insurance Phone Number: _____**Policy holder's Employer:** _____

Dental History

	Yes	No
Is your child currently in pain? ……..		
Has the child experienced problems with previous dental work?.....		
Does your child brush his/her teeth daily? …….		
Does the child have or had orthodontic treatment (braces)? ……..		
Is the child currently under the care of a physician?.....		
If yes, please explain: _____		
Is the patient pregnant? ……..		
How often does you child floss? _____		
What type of water does your child drink? Tap Bottled		

Does your child have any of the following habits?:	Yes	No
Lip Sucking/ Biting…….		
Nail Biting……..		
Chewing on objects…….		
Mouth Breather……..		
Clenching/ Grinding……...		
Pacifier…….		
Nursing Bottle ……..		
Breast Fed ……..		
Thumb/ Finger/ Tongue Sucking……		
Speech Problem……...		

Child's Physician : _____ Phone Number: _____

Has The Child Experienced Any Of The Following? : Circle all that apply

Allergies/Sinus Problems	Congenital Heart Defect	Hospital Stays/ Operations	Mitral Valve Pro-lapse	Handicaps/ Disabilities	Other:
Tuberculosis (TB)	High Blood Pressure	ADHD/ADD	Hemophilia	Measles	_____
Heart Murmur	Rheumatic Fever	Convulsions	Diabetes	AID/HIV	_____
Epilepsy	Hearing Impairment	Kidney Problems	Hepatitis	Autism	_____
Asthma	Learning Disabilities	Liver Problems	Mononucleosis		_____
Blood Transfusion	Sickle Cell Anemia	Tonsillitis	Thyroid Disease		

List All Current Medications:

_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) radiographs, restraint and/or usual recognized techniques to adequately and safely care for the above named patient. I certify that my child is covered by _____insurance company and I assign directly to **Dr. Henry** all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I herby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent/Guardian Date