Child & Youth Information

Please fill in the following information on both sides. Thank you.

Today's Date: ______

Patient's last name: ______ First: ______ Middle: ______

Sex: ☐ Male ☐ Female DOB: ______ School and current grade: ______

Extra curricular activities/hobbies: ______

Street Address: ______ City: ______

State: ______ Zip: ______ Phone #: ______

Father's Name: ______ Address: ______

Preferred Phone #: ______ Email: ______

Mother's Name: ______ Address: ______

Preferred Phone #: ______ Email: ______

Person financially responsible for child/youth: ______

Whom may we thank for referring you to our office? ______

Other family members seen in our office: ______

Preferred method of contact: (Please check one only) ☐ Home ☐ Cell ☐ Email

Dental Insurance Information

Please give your insurance card to the receptionist

Subscriber's name: ______ Subscriber's SSN: ______

Subscriber's DOB: ______

Subscriber's Address: (if different from above) ______

Subscriber's Employer: ______ Subscriber's ID #: (if different from SSN) ______

Dental Ins. Company: ______ Group Number: ______

Dental History

Date of last dental visit: ______ What service was done? ______

Any complaints of dental problems? ☐ Yes ☐ No If yes, what? ______

Unhappy dental experiences? ☐ Yes ☐ No Complications after? ☐ Yes ☐ No

Have you ever experienced injury or trauma to head, face, jaw, mouth, or teeth? ☐ Yes ☐ No

Mouth habits: ☐ thumbsucking ☐ nursing/bottle ☐ pacifier ☐ nailbiting ☐ mouth breathing

Have you ever experienced jaw clicking, popping, or discomfort? ☐ Yes ☐ No

Orthodontic appliances worn now, or in past? ☐ Yes ☐ No

Do you brush teeth daily? ☐ Yes ☐ No Do you assit your child with brushing? ☐ Yes ☐ No

Do you use dental floss? ☐ Yes ☐ No Is fluoride taken? ☐ Yes ☐ No City water? ☐ Yes ☐ No

Patient, parent, or guardian, do you desire complete dental service for the patient? ☐ Yes ☐ No

Please continue on the back…

Health History

Patient's Physician: ____________________ Location: ____________________

Question	Yes	No	
Is patient under care of a physician now?	☐ Yes	☐ No	If yes, list reason: ________
Is patient receiving any medication of drugs?	☐ Yes	☐ No	If yes, list: ________
Is there any excessive bleeding when cut?	☐ Yes	☐ No	
Has the patient ever been hospitalized?	☐ Yes	☐ No	
Has the patient ever had surgery?	☐ Yes	☐ No	
Any allergy to penicillin or other drugs?	☐ Yes	☐ No	If yes, list: ________
Does patient have good physical coordination?	☐ Yes	☐ No	
Are there any emotional problems?	☐ Yes	☐ No	
Does patient use tobacco in any form?	☐ Yes	☐ No	
If female, could patient be pregnant?	☐ Yes	☐ No	
If female, is patient taking birth control pills?	☐ Yes	☐ No	

Has patient had history of, difficulty with, any of the following:

(Check all that apply)

Addiction	☐	Epilepsy	☐	Mastoid	☐
Anemia	☐	Fainting	☐	Measles	☐
Asthma	☐	Hearing	☐	Mononucleosis	☐
Bladder	☐	Heart	☐	Mumps	☐
Cerebral Palsy	☐	HIV	☐	Rheumatic Fever	☐
Chicken Pox	☐	Kidney	☐	Thyroid	☐
Chronic Sinus	☐	Liver	☐	Tuberculosis	☐
Convulsions	☐	Malignancies	☐	Venereal Disease	☐
Diabetes	☐				

Diasability (developmental, physical, emotional) ☐

Other ☐ if yes, please list: ____________________

Please describe any other medical information not discussed above:

____

____

____

____________________ ____________________

Patient's Signature *Date*

____________________ ____________________

Parent or Guardian's Signature *Date*

____________________ ____________________

Dentist's Signature *Date*