**Patient Information**

First Name Last Name Preferred Name Date of Birth (day) \_\_ (mo) \_ (yr) Phone number (Home) \_\_\_\_\_ \_ (Parent Cell) \_\_\_ \_\_\_\_

Address (City) (Postal Code) Email Parents’ Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance**

Primary Plan Employer Group Number

Subscriber Name \_\_\_\_\_\_\_ Subscriber ID # Date of Birth (day) (mo) (yr)

Secondary Plan Employer Group Number

Subscriber Name \_\_\_\_\_\_\_ Subscriber ID # Date of Birth (day) (mo) (yr

**Medical and Dental History**

**General Medical History**

1. Is your child being treated for any medical condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is your child taking any regular medications/inhalers? List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does your child have any allergies to medications, antibiotics or anesthetics? What reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please circle any of the following that your child has been diagnosed as having or been treated for previously:

ADD/ADHD Asthma/Breathing Autism/ASD Bleeding Disorders Cancer

Cerebral Palsy Chicken Pox Cleft lip/Palate Depression/Anxiety Diabetes Digestive Issues Epilepsy/Seizures Fainting spells Heart murmur Herpes/Cold sores Malignant hyperthermia Muscular problems Nervous system Organ Transplant Orthopedic (bones) Rheumatic fever Snoring Speech issues Tonsils/Adenoids

1. Are your child’s immunizations up to date? If not, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child bruise easily or have frequent nose bleeds? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Has your child been hospitalized overnight for illness or injury? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Dental History**

How would you rate the condition of your child’s mouth? Excellent \_ Good \_ Fair \_ Poor \_

Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of most recent visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any x-rays taken?

Dental visits were scheduled every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

1. Has your child had any cavities in the past? \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are any teeth sensitive to hot, cold, biting, sweets, or do es your child avoid brushing any part of their mouth?
3. How nervous is your child for dental visits on a scale of 1 (low) to 10 (high)
4. Has your child ever broken teeth, chipped teeth, or had a toothache or cracked filling?
5. Has your child had any complications from dental treatment in the past? Explain: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_
6. Please indicate any dental conditions or concerns:

Bleeding gums Bruxism (clench/grind) Difficulty freezing Dry mouth Gag reflex Gum recession

Jaw joint concerns Nail biting/Oral habits Orthodontics (braces) Adult teeth eruption timing

**Personal History**

What types of snacks & beverages does your child enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child brush their teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What time of day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often is your child flossing? \_\_\_\_\_\_\_\_\_\_\_\_ Are you still assisting with Oral Hygiene? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other dental concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, certify that I have provided an accurate and complete medical and dental history and have not knowingly omitted any information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

 Parent/Guardian Signature Date

 Dentist Signature Date

Dr. Tina Alexander 250-477-2343