PATIENT INFORMATION FORM
PEDIATRIC AND ADOLESCENT PATIENTS

The information requested below is very important. Please make it as complete and accurate as possible because it will help us provide the best possible health care service. This information becomes part of our permanent records and will be held in strictest confidence. For parents of children, complete the form for your child.

PERSONAL Date: _____

1. Name of the patient _____ Age _____
   Nickname or preferred name (if any) _____ Sex _____
   Date of Birth _____ Place of birth _____
   Home Address: Street _____ City _____
   State _____ Zip _____ Telephone No. _____

2. Are there any other children in the family? Yes ☐ No ☐
   Please give names, sex and ages: _____
   _____

3. Name of father (legal guardian) _____ Social Security No. _____
   Employed by _____ City _____ State _____
   Present Position _____ How long held? _____ Business Phone _____
   Home Address (If different from patient's): Street _____
   City _____ State _____ Zip _____ Home Phone _____

4. Name of mother (legal guardian) _____ Social Security No. _____
   Employed by _____ City _____ State _____
   Present Position _____ How long held? _____ Business Phone _____
   Home Address (If different from patient's): Street _____
   City _____ State _____ Zip _____ Home Phone _____

5. Please check the preferred method of payment: Cash ☐ Check ☐ Mastercard/Visa ☐ Dental Insurance ☐

   Dental Insurance
   Name of Insurance Carrier _____
   Name of employer holding policy _____
   Address: Street _____ City _____
   State _____ Zip _____ Telephone _____
   Name of employee _____ Policy No. _____

DENTAL

1. Please check the reason(s) for seeking dental care:

   ☐ Routine Checkup ☐ Toothache ☐ Bleeding around the teeth
   ☐ Appearance of teeth ☐ Swelling of face ☐ Crowding of teeth
   ☐ Accident to teeth ☐ Other (Specify) _____

2. Has the child or adolescent ever been to the dentist? Yes ☐ No ☐ If yes, was it: A specialist or family dentist

3. When did your child or adolescent last receive dental care? _____

4. Have you been pleased with the child's or adolescent's previous dental care? Yes ☐ No ☐ If No, comment:
   _____

5. Has the child or adolescent had any unfavorable experience in a dental or medical office? If yes, please describe:
   _____

6. How do you think your child will react to dental treatment? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   Comment _____

7. Does your child brush his or her own teeth? Yes ☐ No ☐
   How frequently? _____

8. Do you brush your child's teeth? Yes ☐ No ☐ How frequently? _____
9. Does your child or adolescent use dental floss? Yes ☐ No ☐
10. Do you help the child use dental floss? Yes ☐ No ☐
11. Does the child often have between meal snacks? Yes ☐ No ☐
12. Have the teeth of the child or adolescent ever been injured? Yes ☐ No ☐
13. What was the cause of the accident? _____

How old was the patient? _____ Which teeth were involved? _____

14. Does the child or adolescent currently have any of the following habits? Yes ☐ No ☐ There are no oral habits

☐ Lip sucking ☐ Thumb or finger sucking ☐ Lip biting
☐ Nail biting ☐ Tongue thrusting ☐ Constant mouth breathing

Comment _____

MEDICAL

1. Name of patient's physician _____ Telephone _____
2. Physician's address _____
3. Does the child or adolescent have regular medical examinations? Yes ☐ No ☐ Date of exam _____
4. Were there any difficulties during the pregnancy, delivery or the first year of the child's life? Yes ☐ No ☐
5. If so, Was the child premature? Yes ☐ No ☐ _____
6. Has the child or adolescent been hospitalized since birth? Yes ☐ No ☐ At what age(s) for what reason(s)?
7. _____
8. Is a physician treating the child or adolescent at this time? Yes ☐ No ☐ If yes, for what ? _____
9. Is the child or adolescent taking any medicine at this time? Yes ☐ No ☐

Check what kind: ☐ Antibiotics ☐ Anticoagulants ☐ Anticonvulsants
☐ Cortisone ☐ Other ☐ Tranquilizers

10. Does the child or adolescent have any history of allergies? Yes ☐ No ☐ If so, what? _____

Describe the reaction: _____

11. Has the child or adolescent had an unfavorable reaction to the following drugs? Please check: Yes ☐ No ☐

☐ General Anesthetics ☐ Nitrous Oxide Gas ☐ Aspirin
☐ Local anesthetics ☐ Tranquilizers ☐ Other antibiotics _____
☐ Penicillin ☐ Sedatives
☐ Other medicines _____

12. Has the patient had immunizations for tetanus (DPT, DT)? Yes ☐ No ☐

Indicate approximate date of immunization or last booster? _____

13. Does the patient have a history with any of the following? Please check which one(s):

☐ Hearing difficulties
☐ Speech difficulties
☐ Emotional difficulties
☐ Fainting or dizziness
☐ Poor vision
☐ Liver disease
☐ Diabetes
☐ Bleeding problems
☐ Asthma or wheezing
☐ Rheumatic fever
☐ Kidney disease
☐ Tuberculosis
☐ Skin problems _____
☐ Bone & Joint problems
☐ Epilepsy or seizures
☐ Cerebral palsy
☐ Disease(s) affecting normal growth _____
☐ Anemia
☐ Birth defects _____
☐ Heart problems
☐ Sickle cell anemia
☐ There is NO history of any of these problems.

_____ _____ _____
Signature Relationship to child Date