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? _____