Tooth Story

Please complete both sides of this form so we may give your child the best care.

Todays Date:__________________

Patient Information:

First Name:___________________________ Last Name:_____________________________ (cirlce): Male or Female

Age: _________ Birthdate: ___________________ Home # __________________Cell#__________________________

Text Mesaage Confirmation (CIRCLE): YES or NO Email Address:____

Home Address: _____________________________________ City: _______________________ Zip:______________

Who is Accompanying your child today? _________________ Relationship to patient?___________________________

Do you have legal custody of this child? YES or NO

Mothers Information:

(CIRLCE) Single Married Divorced Widowed Remarried Paternered

Name: ____ Birthdate: _____________________________

Home Address: (If different from above) ____

Home#: ______________________________________ Cell# : ____

Employer: ____ SSN# ___________________________________

Fathers Information:

(CIRLCE) Single Married Divorced Widowed Remarried Paternered

Name: ____ Birthdate: _____________________________

Home Address: (If different from above) ____

Home#_______________________________________ Cell# : ____

Employer: ____ SSN#___________________________________

Primary Dental Insurance:

Insurance Company:______________________ Address: ____

Policy Holder Name:____ DOB: ______________________________

ID#: ___________________________ Group #: ________________________ Employer: ________________________

Secondary Dental Insurance:

Insurance Company:______________________ Address: ____

Policy Holder Name:____ DOB: ______________________________

ID#: __________________________ Group #: ________________________ Employer: ________________________

Responsible Party:

Who is financially responsible for account (if someone other than parents listed above):

____

Patient Name:___________________________ **Nickname:**______________________ **D.O.B.** _______________

<u>Medical History</u>:

Child's Physician: _______________________________________ Phone#: _______________________________

Date of Last Physical Examination: ________ Results: ___________ Child's Weight: ________ Child's Height:_________

Is your child under the care of a physican now? YES or NO Why? ____

Is your child taking any medications? Yes or NO

Drug _____________________________ Dose _________________ Frequency _______________ Reason ___________________________________

Why did you bring the child to the dentist today? ____

Is there any pain or discomfort? ____

Is this your child's first visit? _______ Previous Dentist: ______________________ Last dental visit:______________

Has your child experienced problems with previous dental care? ____

If Yes, Please Explain. ____

Has your child's teeth ever been injured? _______ How? ____

<u>Please circle any medical conditions that the child has or has had:</u>

Allergies- Drugs or Foods Please List: ____

Allergies seasonal	Heart Murmur (Antiobiotic Required?) ________________________	
Accidents or Severe Infections	Cerebral Palsy	Malignancies (Cancer)
AIDS or HIV	Convulsions, Seizures, or Epilepsy	Developmental Disablitlies
Anemia or Blood Disorder	Diabetes	Speech and hearing impairments
Asthma or Lung Problems	Headaches	Bleeding Problems
Autism	Vision Problems	Kidney or Bladder Problems Hyperactivity/ ADHD/ ADD
Hospital Stay or Operations	Skin Problems	
Liver Disease/ Hepatitis	Blood Transfusions	Tuberculosis

Other:____

Please describe any current medical treatment, pending surgery, recent injuries or any other information the dentist should be aware of or that has not been covered above.

____

____

Do you have any special concerns to discuss witht he doctor in private?

____

The signature of a parent or guardian signifies that all of the above information is true and correct.

Signature: _____________________________ Relationship:_______________________ Date:______________

Doctor Signature:____________________________________ Date:___________________________________