TOOTH STORY

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

Today's Date:_______________

Patient Information:

Name:____ ☐ Male or ☐ Female

Age: _____________________ Birthdate:_______________

Home Address:___________________________________ Home Phone #:_________________

___________________________________ Cell Phone#:___________________

Email:__________________________

Who is Accompanying your child today?_________________________ relation:______________

Do you have legal custody of this child? ☐ yes or ☐ no

Mother's Information:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Remarried ☐ Partnered

Name:____

Birthdate:_______________________ SSN:__________________________

Home address: (if different than above)___________________________________

____

Home phone:____________________ Work: ____________________ Cell:_________________

Employer:____

Father's Information:

☐ Single ☐ Married ☐Divorced ☐Widowed ☐Remarried ☐Partnered

Name:____

Birth Date:______________________ SSN:____________________

Home Address: (if different than above) _______________________________

____

Homephone:_________________ Work:___________________ Cell:_____________________

Employer:____

Primary Dental Insurance:

Insurance Company:_________________________ Address:______________________________

Policy Holder:_______________________________ DOB: ___________

ID# __________________________ Group# ______________ Employer_____________________

Secondary Dental Insurance:

Insurance Company:________________________ Address:______________________________

Policy Holder:______________________________ DOB:___________

ID#______________________ Group#:______________ Employer_______________________

Responsible Party:

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

____

Patient's Name _____________________ Nickname______________ D.O.B.________

Medical History:

Child's Physician:______________________________ Phone#________________________

Date of last physical Examination:_________________ Results:________________________

Child's Weight: ______________________ Child's Height:________________________

Is your child under the care of a physician now?___________

Why?____

Is your child taking any medications?

Drug Dose Frequency Reason__________

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

Is there pain or discomfort?____

Is this your child's first visit?______ Previous Dentist________________ last visit________

Has your child experienced problems with previous dental care? _______________________

If yes, please explain.____

Has your child's teeth ever been injured? ________ How? ____________________________

Please check any medical condition that the child has or has had:

- ☐ Allergies - drugs or foods Please list:____
- ☐ Allergies Seasonal
- ☐ Accidents or severe infections
- ☐ AIDS or HIV
- ☐ Anemia or Blood Disorders
- ☐ Asthma or Lung Problems
- ☐ Autism
- ☐ Hyperactivity / ADHD/ ADD
- ☐ Liver Disease/ Hepatitis
- ☐ Malignancies (Cancer)
- ☐ Speech or Hearing Impairments
- ☐ Kidney or Bladder Problems
- ☐ Tuberculosis
- ☐ Heart Murmur (antibiotics required?) __________
- ☐ Cerebral Palsy
- ☐ Convulsions, seizures, or epilepsy
- ☐ Diabetes
- ☐ Headaches
- ☐ Vision Problems
- ☐ Hospital stay or Operations
- ☐ Blood Transfusions
- ☐ Developmental Disabilities
- ☐ Bleeding Problems
- ☐ Skin Problems
- ☐ 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 with the 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:_________

Doctor Notes:____

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