Date: _____ Your **CHILD'S** Confidential Information A B C

Child's Name _____ Nickname _____ Sex _____ Age _____ Birthdate _____
(First & Last)

Address _____
Street City State Zip

Mailing Address _____

Home Phone ( ) _____ Social Security # _____

Email Address _____ Whom may we thank for referring you to our office _____

Confidential Responsible Party Information

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mother/Guardian _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Cell # _____

Previous Address (if Less than 3 yrs) _____
Street City State Zip

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Father/Guardian _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Cell # _____

Previous Address (if Less than 3 yrs) _____
Street City State Zip

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

INSURANCE Information

PRIMARY

Policy Holder's Name _____ Date of birth _____ SS # _____

Insurance Company _____ Group No. _____ I.D. # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____ Do you have dual coverage? Yes ☐ No ☐

SECONDARY

Policy Holder's Name _____ Date of Birth _____ SS # _____

Insurance Company _____ Group No. _____ I.D.# _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of Nearest Relative Not living With You _____

Complete Address _____

Phone _____ Relationship _____

I understand that a parent or guardian must be present at every exam. I authorize the doctor to take x-rays to make a thorough diagnosis of the patient's dental needs. I understand that when appropriate, a credit bureau report may be obtained.

Signature (parent's signature if minor) _____ Update (date & initial) _____

MERCED PEDIATRIC DENTISTRY

DENTISTRY FOR CHILDREN AND YOUNG ADULTS

Health History

This information can be of great value in aiding us to a better understanding of your child in providing dental health care.

MEDICAL

1. Name of family physician or pediatrician
   _____ Telephone_____
   Address _____
2. **Is your child:**
   In good general health right now? Yes ☐ No ☐
   If NO, please describe:
   _____
   _____
   Allergic to penicillin? Yes ☐ No ☐
   Allergic to local anesthetic? Yes ☐ No ☐
   Allergic to latex? Yes ☐ No ☐
   Sensitive or allergic to any medication? Yes ☐ No ☐
   If yes, what medication? _____
   At present taking any medicine? Yes ☐ No ☐
   Current medication?_____
   Allergic to food, animals, pollen, dust? Yes ☐ No ☐
   Other: _____
   History of development delay atypical behavior? Yes ☐ No ☐
   Autism, ADD, ADHD, or OCB? Yes ☐ No ☐
3. **Has your child:** Ever been hospitalized? Yes ☐ No ☐
   If yes, for what?_____
   Had any history or difficulty with any of the following?

Anemia	Y ☐ N ☐	Asthma	Y ☐ N ☐
Bone Disorder	Y ☐ N ☐	Brain Injury	Y ☐ N ☐
Excessive Bleeding	Y ☐ N ☐	Convulsions	Y ☐ N ☐
Cerebral Palsy	Y ☐ N ☐	Diabetes	Y ☐ N ☐
Epilepsy	Y ☐ N ☐	Fainting/Dizziness	Y ☐ N ☐
Hearing	Y ☐ N ☐	Hepatitis	Y ☐ N ☐
HIV Virus	Y ☐ N ☐	Heart Trouble	Y ☐ N ☐
Kidney/Bladder	Y ☐ N ☐	Liver	Y ☐ N ☐
Cancer or malignancies	Y ☐ N ☐	Rheumatic Fever	Y ☐ N ☐

   Speech Impediment Y ☐ N ☐
   If the answer is YES, explain.
   _____
   _____
   Was your child full term? Yes ☐ No ☐
4. How would you expect your child to behave in our office?_____
5. Would you describe your child as:
   Shy ☐ Frightened ☐ Apprehensive ☐ Normal ☐
6. Names and ages of brothers and sisters_____
   _____
7. School Name & Grade _____

DENTAL

1. Is this an emergency visit? Yes ☐ No ☐
   Explain _____
2. Is this the first visit to a dentist? Yes ☐ No ☐
3. Has any member of your family previously been a patient of this office? Yes ☐ No ☐
   Name(s) and age(s)_____
   _____
4. Present dental problem as you see it (if any)
   _____
   _____
5. Has your child complained about dental problems? Yes ☐ No ☐
   Describe_____
6. Has your child had any unhappy experiences with dental care? Yes ☐ No ☐
7. Any mouth habits: Thumbsucking, pacifier, nail biting, finger sucking? Yes ☐ No ☐
   If YES, describe _____
   _____
8. Has your child had any history of cavities, toothaches, pain, broken teeth, extracted teeth, gum infections, missing permanent teeth, or extra teeth? Yes ☐ No ☐
   If YES, please **underline** the condition(s).
9. Has your child ever had an injury to the head, mouth or teeth? Yes ☐ No ☐
   Describe_____
10. Name your child's favorite toy, hobby, TV show, etc.
    _____
    _____
11. Does your child brush daily? Yes ☐ No ☐
12. Do you assist child with brushing? Yes ☐ No ☐
13. Is dental floss used? Yes ☐ No ☐
14. Is fluoride taken? Yes ☐ No ☐
15. Has mother or father had a lot of tooth decay? Yes ☐ No ☐
    Name of former dentist _____
    Address_____Telephone_____

Signature of Parent or Guardian _____

Updates (date & initial) _____