



## A CARING DENTAL GROUP

Please complete the following confidential information: Today's date: \_\_\_\_\_

### TELL US ABOUT YOUR CHILD

Child Name \_\_\_\_\_ Nickname \_\_\_\_\_ Male Female  
Child's Birthday \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_  
School: \_\_\_\_\_ Phone # \_\_\_\_\_  
Child's Physician: \_\_\_\_\_ Phone # \_\_\_\_\_  
Who was your child's former dentist? \_\_\_\_\_  
Does your child have any oral habits? Please circle.  
Thumb sucking lip-biting nail biting nursing bottle habits  
Childs home address: \_\_\_\_\_  
Phone # \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

Mothers Information: SSN \_\_\_\_\_ Fathers Information: SSN \_\_\_\_\_  
Name \_\_\_\_\_ Birthday \_\_\_\_\_ Name \_\_\_\_\_ Birthday \_\_\_\_\_  
Dental Ins: \_\_\_\_\_ Group # \_\_\_\_\_ Dental Ins: \_\_\_\_\_ Group # \_\_\_\_\_  
Employer \_\_\_\_\_ Employer \_\_\_\_\_  
Work # \_\_\_\_\_ Work # \_\_\_\_\_  
Home address if different from child \_\_\_\_\_ Home address if different from child \_\_\_\_\_  
Marital status \_\_\_\_\_ Marital status \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_  
Closest relative: \_\_\_\_\_ Address \_\_\_\_\_  
In case of emergency, whom should we contact? \_\_\_\_\_

### Medical History:

Is your child in good health: Yes No  
Any hospital stays? Yes No if so, what for? \_\_\_\_\_

### Has your child been immunized for:

Diphtheria, Whooping cough (pertussis) and Tetanus.	Yes	No
Polio	Yes	No
Measles and German Measles (rubella)	Yes	No

### Has your child had a DPT and Polio Booster?

At 1 – 2 years	Yes	No
At 3 – 4 years	Yes	No
Diphtheria and Tetanus (adult type) every 10 years thereafter	Yes	No

Has your child been put to sleep for medical/dental treatment? Yes No  
Is your child allergic to any drugs? Yes No

If yes, please list \_\_\_\_\_

### Does your child have a problem with any of the following? (Please circle)

School	epilepsy	kidney	HIV/AIDS
Seizures	asthma	cleft palate	nervousness
Tuberculosis	cerebral Palsy	heart murmur	hemophilia
			cancer

### Are there any other conditions we should be aware of?

If yes, please list. \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge, and I am responsible to inform the office of any changes in my Childs medical status.

Parents Signature \_\_\_\_\_