TRIPLE CITIES
FAMILY DENTAL, P.C.

CHILD
ACCOUNT INFORMATION

TODAY'S DATE_____

CHILD'S NAME_____ SEX_____ BIRTHDATE_____

LOCAL ADDRESS_____ LOCAL PHONE # _____

_____ CELL PHONE #_____

BILLING ADDRESS (IF DIFFERENT)_____

FATHER_____ BIRTHDATE _____ SS # _____

EMPLOYER_____ WK. #_____ DRIVERS LIC. #_____

MOTHER_____ BIRTHDATE _____ SS # _____

EMPLOYER_____ WK. #_____ DRIVERS LIC. #_____

PERSON RESPONSIBLE FOR DENTAL INVESTMENT_____

SOMEONE TO NOTIFY IN CASE OF AN EMERGENCY_____

ADDRESS_____ PHONE # _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
EMPLOYEE _____	EMPLOYEE_____
INSURANCE CO. _____	INSURANCE CO. _____
ADDRESS _____	ADDRESS _____
_____	_____
GROUP #_____	GROUP #_____
SUBSCRIBER ID #_____	

IF INSURANCE IS THROUGH STEP-PARENT:

NAME_____ SS # _____

ADDRESS _____

BIRTHDATE_____ EMPLOYER _____

MEDICAL HISTORY

PLEASE CIRCLE THE APPROPRIATE RESPONSE. IF YOU DON'T KNOW THE CORRECT ANSWER, WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____

   Address _____

2. Does your child have a history of the following?

   a. Diabetes ..... **YES** **NO**

   b. Heart murmur of cardiac disorder ..... **YES** **NO**

   c. Asthma ..... **YES** **NO**

   d. Kidney disease ..... **YES** **NO**

   e. Rheumatic fever ..... **YES** **NO**

   f. Epilepsy ..... **YES** **NO**

   g. Cerebral palsy ..... **YES** **NO**

   h. Liver problems ..... **YES** **NO**

   i. Congenital birth defect ..... **YES** **NO**

   j. Severe or prolonged bleeding ..... **YES** **NO**

   k. Mental retardation ..... **YES** **NO**

   l. Cancer ..... **YES** **NO**

   m. Eyesight problems ..... **YES** **NO**

   n. Speech impairment ..... **YES** **NO**

   o. Hearing loss ..... **YES** **NO**

   p. Spina Bifida ..... **YES** **NO**

3. Has your child tested HIV positive ..... **YES** **NO**

4. Has your child tested positive for hepatitis? ..... **YES** **NO**

5. Is your child subject to nervous disorders? ..... **YES** **NO**

   Circle: Fainting, Seizures, Dizziness

6. Does your child have frequent headaches? ..... **YES** **NO**

7. Does your child have any health problem or serious illness that is not listed above? ..... **YES** **NO**

   If so, what? .....

8. Has your child ever had surgery? ..... **YES** **NO**

9. Is your child taking any medications? ..... **YES** **NO**

   What? .....

10. Is your child allergic to penicillin, antibiotics or other drugs? ..... **YES** **NO**

DENTAL HISTORY

1. Is this your child's first visit to a dentist? ..... **YES** **NO**
2. If not, how long since the last visit? .....
3. Were any x-rays taken when your child previously visited the dentist? ..... **YES** **NO**
4. When does your child brush his/her teeth? .....
5. Is there fluoride in the water where you live? ..... **YES** **NO**
6. Is your child taking fluoride drops or tablets? ..... **YES** **NO**
7. Have any cavities been noted in the past? ..... **YES** **NO**
8. Were any teeth (baby or permanent) removed by extraction? ..... **YES** **NO**
9. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... **YES** **NO**

   If yes, describe _____
10. Have tonsils and/or adenoids been removed? ..... **YES** **NO**
11. Does your child have frequent canker or cold sores? ..... **YES** **NO**
12. Is your child a "mouth breather"? ..... **YES** **NO**
13. Does your child gag easily? ..... **YES** **NO**
14. Did or does your child go to sleep with a bottle? ..... **YES** **NO**
15. Did or does your child have a thumb sucking habit? ..... **YES** **NO**
16. Has your child ever had an adverse reaction to local anesthetic (Novocaine)? ..... **YES** **NO**
17. Does your child think there is anything wrong with his/her teeth? ..... **YES** **NO**
18. Has your child had any problem with dental treatment in the past? ..... **YES** **NO**
19. Is there anything about your child's behavioral pattern which you think will make dental treatment difficult? ..... **YES** **NO**

    Remarks: _____
20. Is there anything you wish to discuss with the Doctor privately? ..... **YES** **NO**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Parent / Guardian Date