TOTAL DENTAL CARE

of Middle Island, P.C.

PATIENT INFORMATION (CHILD)

Date

Child's Name

Date of Birth Age
Sex: □ Male □ Female

School Grade

Child's Favorite Interest/Hobby

Address

City State Zip

Home Phone

Who is Responsible for this account?

Relationship to Patient

Responsible Party's SS# (required)

Mother's Name

Mother's Occupation

Mother's Employer *Phone*

Employer's Address

Mother's Cell Phone

Father's Name

Father's Occupation

Father's Employer *Phone*

Employer's Address

Father's Cell Phone

INSURANCE INFORMATION:

Dental Insurance (Primary)

Subscriber's Name

Subscriber's SS# or ID#

Group#

Dental Insurance (Secondary)

Subscriber's Name

Subscriber's SS# or ID #

Group#

Email Address (Parent/Guardian)

Whom may we thank for referring you?

Have you seen/heard any of our advertising?
□ Newspaper □ Movie Theater □ Mailings □ Website
□ Radio If yes, what radio station ? _____

DENTAL INFORMATION:
Is this your child's first dental visit? □ YES □ NO
Date of last visit_____

Present dental problem as you see it (if any)

Does your child brush daily? □ YES □ NO
If yes, when? _____
Does an adult assist with brushing? □ YES □ NO
What toothpaste does your child use _____

Has your child ever had xrays taken?□ YES □ NO

Has your child ever had Novocaine? □ YES □ NO
If yes, by which doctor? _____
Were there any complications?

Does your child have any of the following bad habits:
□use of bottle □ pacifier □nail biting
□ finger sucking □ thumb sucking □ tongue thrusting
□ mouth breathing □ tooth grinding

Does your child receive fluoride in any of the following forms:
□ water supply □ toothpaste □ mouthwash/rinse
□ vitamins
Vitamin Name/Dosage _____

How has your child reacted to previous dental visits?_____

How do you expect your child to react today?
□ excellent □ good □ fair □ poor
□ don't know

MEDICAL HISTORY: CERTAIN ILLNESSES OR DRUGS MAY MAKE IT NECESSARY TO ALTER OUR TREATMENT IN OUR ENDEAVOR TO RENDER THE BEST POSSIBLE ORAL HEALTH CARE TO YOUR CHILD. IT IS NECESSARY TO HAVE THE FOLLOWING INFORMATION.

Child's Pediatrician

Address

City State Zip

Phone

Date of child's last physical and reason

HAVE YOU EVER OR NOW HAVE (PLEASE CHECK YES OR NO):

Y	N	
□	□	AIDS
□	□	ALLERGIES TO MEDICINE
□	□	ANEMIA
□	□	ASTHMA
□	□	AUTISM
□	□	BLADDER CONDITIONS
□	□	BLOOD TRANSFUSIONS
□	□	BIRTH DEFECTS
□	□	BONE OR JOINT PROBLEMS
□	□	BRAIN INJURY
□	□	BRUISING EASILY
□	□	CANCER OR MALIGNANCIES
□	□	CEREBRAL PALSY
□	□	CHILD ABUSE
□	□	CHRONIC ADNOID/TONSIL INFECTION
□	□	CHRONIC HEADACHES
□	□	CHRONIC EAR INFECTION
□	□	CLEFT PALATE/LIP
□	□	CONVULSIONS/SEIZURES
□	□	DEVELOPMENTAL DELAY
□	□	DIABETES
□	□	DRUG/ALCOHOL ABUSE
□	□	EMOTIONAL DISTURBANCE
□	□	EPILEPSY
□	□	EYE PROBLEM
□	□	EXCESSIVE BLEEDING
□	□	EXCESSIVE GAGGING
□	□	FAINTING OR DIZZINESS
□	□	FREQUENT INFECTIONS
□	□	GROWTH AND DEVELP-MENTAL PROBLEMS
□	□	HEARING/SPEECH PROBLEM
□	□	HEART MURMUR/DEFECT
□	□	HEMOPHELIA
□	□	HEPATITIS/LIVER DISEASE
□	□	HYPERACTIVITY
□	□	JAUNDICE
□	□	MITRAL VALVE PROLAPSE
□	□	PIN/JOINT REPLACEMENTS
□	□	KIDNEY DISEASE
□	□	LEUKEMIA
□	□	MENTAL RETARDATION
□	□	NUTRITIONAL/EATING DISORDER
□	□	ORAL ULCERS
□	□	ORTHOPEDIC PROBLEMS
□	□	PNEUMONIA
□	□	PREMATURE BIRTH
□	□	RHEUMATIC FEVER
□	□	SCOLIOSIS
□	□	SICKLE CELL ENEMIA
□	□	SINUS PROBLEMS
□	□	SORE THROAT (FREQUENT)
□	□	SPINA BIFIDA
□	□	SYNDROME/TYPE
□	□	TUBERCULOSIS
□	□	OTHER

Is your child in good health?
□ YES □ NO
Are your child's immunizations up to date?
□ YES □NO

Is your child being treated for any condition presently?
□ YES □ NO If so, explain, _____
_____
Is your child taking any medication (including vitamins)?
□ YES □ NO If so, explain_____
_____
Has your child ever been hospitalized/had general anesthesia or sedation?
□ YES □ NO
Does your child have any allergies or reactions to medications?
□ YES □ NO If so, explain_____
_____
Does your child have any allergies to the following:
□Pollen □Dust □Food □Food Dyes □Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been covered_____
_____

AUTHORIZATION AND FINANCIAL RESPONSIBILTY

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/ALL NECESSARY SERVICES CAN BE PERFORMED. I ACKNOWLEDGE THAT THE INFORMATION ABOVE AND ON THE OTHER SIDE IS CORRECT. I AUTHORIZE THE DOCTOR TO TAKE XRAYS, PHOTOGRAPHS, OR OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS AND GRANT THIS OFFICE TO PROVIDE MY CHILD'S DENTAL TREATMENT. THIS CONSENT IS ALSO VALID FOR EMERGENCY DENTAL TREATMENT. IF NECESSARY, EVEN IN MY ABSENCE. FURTHERMORE, I UNDERSTAND THAT IF MY INSURANCE DOES NOT COVER THE COST OF THIS DENTAL CARE, I WILL BECOME FINANCIALLY RESPONSIBLE FOR IT.

_____
SIGNATURE OF PARENT/GUARDIAN
_____
DATE
_____
RELATIONSHIP TO CHILD
_____
WITNESS
_____
DOCTOR'S SIGNATURE

UPDATES

Has there been any changes in your health since your last dental appointment?

□YES □NO _____
PARENT/GUARDIAN DATE
_____
DOCTOR DATE

□YES □NO _____
PARENT/GUARDIAN DATE
_____
DOCTOR DATE