Today's Date:_____

Child Information

Patient's Full Name: _____Gender:__M__F
Nickname: _____Date of Birth: _____
School Name: _____
How did you hear about us?: _____

Insurance

Insurance Company Name:_____
Policy Holder/Subscriber's Full Name: _____
Date of Birth of Subscriber: _____
Social Security Number of Subscriber: _____-_____-_____
Member ID #: _____
Group/Policy #: _____
Employer Name: _____
Insurance Company Phone #: _____'

Contact Information

Best Daytime Cell: _____
Secondary Cell: _____
Email: _____
Secondary Email:_____

Address

Address of Patient: _____
Address of Responsible Insurer[if different from above]: _____

Child's Medical

Do you have any concerns with your child's teeth?: _____
How do you expect your child will respond to dental treatment? ___**Very Well** ___**Fairly Well** ___**Poor** ___**Very Poor**
When was your child's last dental check up [if any]?: _____
Is your child presently in any dental pain?: **Y or N If So, please explain**: _____
Has your child ever had trauma to the head, face, or teeth? **Y or N If So, please explain**: _____
Does your child have any extra, missing, or extracted teeth? **Y or N** Does your child grind their teeth? **Y or N**

Home Care

Does your child use a fluoride toothpaste? **Y or N** Who brushes your child's teeth? ___**self** ___**parent** ___**both**
How often does your child brush their teeth? _____ Does your child floss daily? **Y or N**
Primary source of drinking water? ___**city/tap** ___**well** ___**filter** ____**bottle**
Does your child have a finer/thumb/pacifier habit? **Y or N**
If your child participates in sports, do they wear a mouth guard? **Y or N**

Medical

Does your child require antibiotics for dental cleanings and treatment? **Y or N**
Does your child have any syndromes or special needs? **Y or N If so, please explain:**_____
_____
Is your child allergic to penicillin? **Y or N**
Is your child allergic to latex? **Y or N**
Is your child allergic to peanuts/tree nuts? **Y or N**
Does your child have any other allergies to medications or other substances? **Y or N If so, please explain:** _____
Please list all medications currently being taken: _____

Please check any conditions that may apply to your child:

___ ADD/ADHD ___Cystic Fibrosis ___ Heart Murmur/Defect
___ Asthma ___ Developmental Delay ___ Sensory Disorder
___Autism/ASD ___ Diabetes ___ Speech Delay
___Cancer/Tumor ___Epilepsy/Seizures ___ Other: _____

I have read and understand the above questions and this office's privacy policies. I will not hold Innovative Pediatric Dentistry responsible for any errors or omissions. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes.

Responsible Party: _____