



Welcome

Chester Family Dental Care

Personal Information:

Child's Name: _____ Date: _____

Child's Address: _____

City: _____ State: _____ Zip Code: _____

Person accompanying child for today's visit: _____ Relationship _____

Are you the legal guardian? Yes No Phone Number: Home _____ Cell: _____

Child's Birthdate ____/____/____ Social Security: ____-____-____ Gender: Male Female

Insurance

Do you have any dental insurance? Yes No If so, please provide insurance card.

Employer Name: _____

Child's Family Information

Guardian/Mother's/Step-Mother's Name: _____

Address (if different from child): _____

City: _____ State: _____ Zip: _____

Phone Number: Home _____ Work: _____ Cell: _____

Mother's SSN : _____ - _____ - _____ Date of Birth: ____/____/____

Father's/Step-Father's Name: _____

Address (if different from child): _____

City: _____ State: _____ Zip: _____

Phone Number: Home _____ Work: _____ Cell: _____

Father's SSN : _____ - _____ - _____ Date of Birth: ____/____/____

Medical History:

Primary Physician Name: _____ Phone: _____

Is your child currently being treated by a physician? ___ Yes ___ No

If yes, please explain. _____

Has he/she been hospitalized? ___ Yes ___ No If yes, please explain. _____

Has he/she had any major operations? ___ Yes ___ No

If so, please list operations: _____

Does he/she have any artificial joints? ___ Yes ___ No If yes, please explain _____

Does he/she need any pre-med? ___ Yes ___ No If yes, what have you taken? _____

Is he/she taking any medications, pills, or drugs? ___ Yes ___ No

Please list any medications. (Prescription or over the counter)

Is he/she allergic to or have any reactions to the following (circle):

Y N Latex Y N Penicillin Y N Sulfa drugs Y N Codeine Y N Aspirin

Y N Barbiturates Y N Iodine Y N Metal allergy Y N Sedatives

Any other allergies _____

Does your child have or have you had any of the following (circle):

- Y N Bleeding Problems Y N Emphysema Y N Heart Surgery
- Y N Anemia Y N COPD Y N Heart Attack/Stroke
- Y N Abnormal Bleeding Y N Hepatitis Y N Heart Murmur
- Y N Hemophilia Y N Leukemia Y N Artificial Heart Valve
- Y N Convulsions/Epilepsy Y N Asthma Y N Heart Disease
- Y N Cancer/Tumor Y N Tuberculosis Y N Mitral Valve Prolapse
- Y N Psychiatric Problems Y N Joint Replacement Y N Congenital Heart Defect
- Y N Diabetes: Type I or II Y N Fainting/Seizures/Epilepsy Y N Chest Pains
- Y N HIV/Aids Y N Stomach Problems/Ulcers Y N Pacemaker
- Y N Substance Abuse Y N Low/High Blood Pressure Y N Blood Thinner
- Y N Radiation/Chemotherapy Y N Thyroid/Kidney/Liver Problems

Y N Pregnant: if so when is due date: _____

Dental Health

Is your child experiencing any of the following?

- Y N Bleeding gums while brushing Y N Clenching or grinding of teeth
- Y N Tooth sensitivity to hot/cold Y N Difficulty with past extractions
- Y N Pain in any of your teeth Y N Any orthodontic treatment
- Y N Sores or lumps in or near the mouth Y N Unhappy with the way your teeth look
- Y N Head, neck, or jaw injuries Y N Periodontal Disease
- Y N Interested in whitening your teeth

Authorization and Release: I hereby authorize the dentist or designated staff to perform diagnostic procedures and treatment mutually agreed upon by me as may be required for proper dental care. I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or dentist. I attest to the accuracy of the information on this form and understand that this examination will address my immediate problem and confirm this is not a complete examination and/or treatment. To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in your child's medical status.

Responsible party's signature

Date