James River Dentistry
We would like to get to know you better!

Date_____ Home Phone_____ Cell Phone_____

Patient's Name_____

Last First MI Preferred

Sex: M_____ F_____ Birthdate_____ SS#_____

Parent's Name_____ Telephone_____

Address_____ City_____ State_____ Zip_____

Parent Employer_____ Work Phone_____

Current Position_____

Who will pay this account?_____

Who referred you to our office?_____

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Dental Insurance

Name of carrier_____

Subscriber ID #_____ Group #_____

Are you covered by another plan? _____

If so, name of carrier_____

Subscriber ID #_____ Group #_____

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Dental History

	Yes	No
Is this the child's first dental visit?	____	____
If not, how long since last visit? _____		
Does child eat between meals?	____	____
Does child eat sweets, such as candy pop, and chewing gum?	____	____
Does child eat a well balanced diet?	____	____
Does child brush teeth upon arising?	____	____
When going to bed?	____	____
After eating meals?	____	____
After eating any food?	____	____
Have teeth been treated with fluorides?	____	____

	Yes	No
Have any cavities been noted in the past?	____	____
Were any teeth (baby or permanent) removed by extraction?	____	____
Was it suggested that the space be maintained?	____	____
Was appliance placed?	____	____
Have there been any injuries to the teeth? Falls, blows, chips, etc?	____	____
If yes, please explain_____		
Has child had any unfavorable dental experiences?	____	____

_____ _____

Parent signature **Date**