DURAN DENTAL CENTER, INC.

CHILD PATIENT INFORMATION

Please complete this form so we can provide safe, personalized dental care for your child.

1 Tell Us About Your Child

Today's Date | Child's Name (Last, First, MI) | Birthdate | Age

Nickname | Sex | School | Grade

Male Female

Child's Home Phone | SS # | Child's Home Address

2 General Information

Who is accompanying the child today? | Relation | Legal custody?

Yes No

Whom may we thank for referring you? | Other siblings

Previous / Present Dentist | Last Visit Date | Dentist's Phone

Relative/Friend not living with you - Name | Phone | Address

3 Parent / Guardian Information

Person Responsible for Account

Marital Status

Single | Married | Partnered

Widowed | Divorced | Separated

Parent / Guardian 1

Name

Birthdate

Address (if different than child's)

Home / Cell Phone

Email

Employer

Work Phone

Parent / Guardian 2

Name

Birthdate

Address (if different than child's)

Home / Cell Phone

Email

Employer

Work Phone

Dental Insurance

Insurance Company

Insurance Address

Insurance Phone

Group / Plan / Policy #

Insurance Company

Insurance Address

Insurance Phone

Group / Plan / Policy #

4 Release & Authorization

I certify that my child is covered by the insurance information provided, if applicable. I understand that I am responsible for payment of services rendered and any co-payment or deductible not covered by insurance. I authorize Duran Dental Center, Inc. to release information necessary to secure payment of benefits and to use this authorization for insurance submissions, whether manual or electronic.

Signature of Parent / Guardian

Date

5 Dental History

Why did you bring the child to the dentist today?

Has the child ever taken Fosamax or any other bisphosphonate?	Yes	No
Has your child ever taken Phen-Fen?	Yes	No
Is the child currently in pain?	Yes	No
Does the child require antibiotics before dental treatment?	Yes	No
Has the child ever had a serious/difficult problem associated with previous dental work?	Yes	No
Is the child's water fluoridated?	Yes	No
Is the child taking fluoridated supplements?	Yes	No
Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)?	Yes	No
Does the child brush their teeth daily?	Yes	No
Does the child floss daily?	Yes	No

Child's Physician Phone Date of Last Visit

Is the child currently under the care of a physician?

Yes No

Describe the child's current physical health Rating

Good Fair Poor

All drugs / medications the child is currently taking

All allergies / substances the child is allergic to

Known material allergies: Latex Metals / Nickel Plastic

6 Medical History

Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur	Y	N
ADD / ADHD	Y	N	Hepatitis	Y	N
AIDS / HIV+	Y	N	High Blood Pressure	Y	N
Anemia	Y	N	Hives	Y	N
Hospital Stays / Operations	Y	N	Kidney Problems	Y	N
Artificial Bones / Joints / Valves	Y	N	Liver Problems	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N
Cancer	Y	N	Lupus	Y	N
Chicken Pox	Y	N	Measles	Y	N
Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N
Convulsions	Y	N	Mononucleosis	Y	N
Diabetes	Y	N	Prosthetics	Y	N
Epilepsy	Y	N	Rheumatic Fever	Y	N
Exposure to HIV, TB, NG	Y	N	Scarlet Fever	Y	N
Handicaps / Disabilities	Y	N	Skin Rash	Y	N
Hearing Impairment	Y	N	Tuberculosis (TB)	Y	N

Are the child's immunizations current? Yes No

Anything to discuss privately? Yes No

Please describe any serious medical problems or concerns

Habits / Concerns - check any that apply

Breast Fed	Mouth Breather	Thumb/Finger Sucking
Chewing on Objects	Nail Biting	Tongue/Cheek Biting
Clenching/Grinding Teeth	Nursing Bottle Habits	Tongue Thrust
Lip Sucking/Biting	Speech Problems	Used Pacifier

I affirm that the information I have given is correct to the best of my knowledge. I will inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent / Guardian

Date

OFFICE USE ONLY

Dentist Signature / Review

Date

Dentist Comments