YOUNG
DENTISTRY

PATIENT INFORMATION

Your Child's Name:_____ Nickname:_____

Date of Birth:_____ /_____ /_____ Age: _____ Identifies Male: _____ Female: _____

School: _____ Grade: _____

Child's primary address: _____

City: _____ Zip:_____ Telephone:_____

Parent/Legal Guardian #1:

Name:_____ Date of Birth: _____ /_____ /_____

Occupation/Employer: _____ SS#:_____

Work phone: _____ Mobile: _____ Home: _____

Email address:_____

Parent/Legal Guardian #2:

Name:_____ Date of Birth: _____ /_____ /_____

Occupation/Employer: _____ SS#:_____

Work phone: _____ Mobile: _____ Home: _____

Email address:_____

Method of confirming appointments (circle one): Text Phone Email

Parent's Marital Status (circle one):

Single Married Divorced Widowed Separated

Who is accompanying the child today?

Name: _____ Relationship: _____

Whom may we thank for referring you to our office? Doctor Friend Facebook Google Other

Name of doctor, friend, or patient who told you about us: _____

Person Responsible for Account:

Name:_____ Relationship to child:_____

Date of Birth: _____ / _____ / _____ SS#_____

Billing Address (if different from child): _____

Email: _____ Mobile phone:_____

Method of Billing Preference (circle one): Email or Mail

Dental History

Please circle the reason(s) for today's visit:

Complete checkup Toothache Accident to teeth Appearance of teeth

Other: _____

Is this your child's first visit to the dentist? _____ Y _____N

If not, when was your child's last visit to the dentist? _____

Was it a family dentist or specialist? Name of previous dentist: _____

Other dentists, orthodontists oral surgeons your family has seen:

_____

Were previous x-rays taken? _____Y _____ N If yes, when? _____

Any unhappy dental experience? _____ Y _____ N If yes, please explain

_____

_____

Any injury to the mouth or teeth? _____Y _____N If yes, please explain:

_____

_____

Does your child drink tap water? _____Y _____N Filter/type: _____

How often does your child brush?_____ Alone or with help? _____

Does your child floss? _____Y _____N How often? _____

Please circle if your child has any mouth habits?

Thumb sucking Nail Biting Mouth breathing Pacifier Lip sucking Tongue thrusting

Grinding/Clenching Other:_____

How do you think your child will react to dental treatment?

_____ Excellent _____ Good_____ Fair _____ Poor _____ I don't know

Any unusual speech habits? _____Y _____N

Is there any special information that you believe would be helpful to us in your child's visit today or in general? Please comment: _____

_____

_____

Medical History

Name of Pediatrician: _____ Phone: _____

Date of last exam: _____ Vaccinations up to date? _____ Y _____N

Current medications: _____

History of allergies? _____ Y _____ N

If yes, circle all that apply: Penicillin Aspirin Anesthesia Latex Food Other

_____

Describe symptoms of reaction: _____

Has your child ever had any of the following? Please circle

Abnormal Bleeding	ADD/ADHD	AIDS/HIV	Allergy	Anemia
Anxiety	Asthma	Autism	Cancer	Cleft Lip/Palate
Depression	Diabetes	Epilepsy	Fainting	Headaches
Heart Disease	Heart Murmur	Hepatitis	Kidney problems	
Liver problems	Mental Delays	Measles	Muscle weakness	
Mumps	PDD	Physical delays	Pregnancy	Psychiatric care
Rheumatic Fever	Seizures	Sinus problems	Sickle Cell Anemia	
Bone or joint problems	Birth Defects	Turberculosis	Other: _____	

Please describe: _____

Has your child ever been hospitalized? _____

Does your child see any specialists? _____

Any medical treatments including drugs, pending surgery, recent injuries or any information that you would like to make us aware of that has not been covered?

_____

Is there anything you would like to discuss with the doctor in private or without your child being present?

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can put my child's health at risk, and that it is my responsibility to inform Young Dentistry of any changes in my child's health status.

Signature of Parent/Legal Guardian: _____ Date: _____