Patient Information

Child's complete name: _____ Nickname: _____

Date of Birth: _____ Sex: M / F Telephone: _____

Mailing address: _____ Apartment #: _____

City: _____ State: _____ Zip Code:_____

Parent 1: Name_____ Date of Birth: _____ SSN: _____

Employer: _____ Occupation: _____

Business phone: _____ Cell phone: _____ Home phone: _____

Email Address: _____

Parent 2: Name_____ Date of Birth: _____ SSN: _____

Employer: _____ Occupation: _____

Business phone: _____ Cell phone: _____ Home phone: _____

Email Address: _____

Marital Status: Married ____ Single ____ Divorced ____ Widowed ____ Other _____

Child lives with: Both Parents ____ Parent 1 ____ Parent 2 ____ Other _____

Name and age of siblings, if any: _____

Are they existing Epic Dental patients? Yes ____ No ____

Whom may we thank for referring you? _____

Child's Pediatrician: _____ Date of last visit:_____

Address: _____ Phone number: _____

INITIALS _____

Dental Information

Reason(s) for dental care:

___First Examination
___Routine Check-up
___Toothache or Swelling
___Second Opinion
___Trauma/Accident
___Consultation
___Appearance
___Other _____

Do you have any concerns regarding your child's dental health that you would like to address?

_____

Has your child had any negative dental experiences? Yes No If Yes, please explain:

_____

How do you expect your child to react to the visit today? Excellent ___ Good ___ Fair ___ Poor ___
Please check any of the following that may describe your child;

___Outgoing
___Shy
___Cooperative
___Anxious
___Stubborn
___Trusting
___Friendly
___Moody

Does your child receive fluoride in any of the following forms? *Please circle*

Vitamins Water Tablets/Drops Rinse/Gel

Does your child brush daily? Yes ___ No ___
Does an adult assist with brushing? Yes ___ No ___
Does your child use dental floss? Yes ___ No ___

Does your child have any of the following habitsP:

Pacifier___ Thumb/finger Sucking ___ Teeth grinding ___ Mouth breathing ___
Tongue habit ___ Bottle with milk or juice in bed ___

Has your child's teeth ever been injured? Yes ___ No ___ If Yes, at what age? ____
Which teeth? _____ Cause and treatment received? _____

Has your child had dental radiographs (x-ray)? Yes ___ No ___ If Yes, when? _____

INITIALS _____

Medical Information

Is your child being treated for any condition presently? Yes ___ No ___ If Yes, please explain: _____

Is your child taking any medications? Yes ___ No ___ If Yes, please list:

Medication/Drug	Reason

Has your child ever had an allergic or unusual reaction to a medication or drug? Yes ___ No ___
If Yes, please explain: _____

Does your child have any allergies to the following? *Please circle*:

Latex Foods _____ Food Dyes Penicillin Other_____

Has your child ever been hospitalized? Yes ___ No ___ If Yes, please explain: _____
Has your child ever had any surgery? Yes ___ No ___ If Yes, please explain: _____
Was general anesthesia used? Yes ___ No ___ If Yes, any complications?_____
Are your child's immunizations current? Yes ___ No ___

Has your child ever been diagnosed with a heart condition that requires antibiotics prior to dental treatment? Yes ___ No ___ If yes, please explain: _____

Does your child have any history of the following diseases or condition?

Yes	No	Yes	No	Yes	No
___	___Allergies to meds/food	___	___Chronic Ear Infection	___	___Immune Disorder
___	___Anemia or blood disorder	___	___Cleft Lip/Palate	___	___Kidney Disease
___	___Arthritis	___	___Convulsions/seizures	___	___Leukemia
___	___Asthma	___	___Diabetes	___	___Mental Retardation
___	___ADD	___	___Down syndrome	___	___Neurological Prob
___	___Autism	___	___Emotional Disturbance	___	___Nutrional Deficiency
___	___Behavioral Disorder	___	___Epilepsy	___	___Oral ulcers
___	___Bladder conditions	___	___Excessive bleeding	___	___Premature birth
___	___Blood Transfusions	___	___Excessive gagging	___	___Rheumatic fever
___	___Birth defects	___	___Fainting or dizziness	___	___Scoliosis
___	___Bone or joint problems	___	___Growth or development problems	___	___Sickle cell anemia
___	___Brain injury	___	___Hearing/speech problems	___	___Sleep apnea
___	___Bruising easily	___	___Heart Disease	___	___Spina Bifida
___	___Cancer or Malignancies	___	___Heart murmur	___	___Syndrome
___	___Cerebral disorder	___	___Hemophilia	___	___Tuberculosis
___	___Child abuse	___	___Hepatitis or liver disease	___	___Visual impairment
___	___Chronic adenoid/tonsil infection	___	___Hyperactivity	___	Other_____
___	___Chronic headaches	___	___HIV/Aids		

INITIALS _____