CHILDREN'S PATIENT FORM

Date:(MM/DD/YY)______________________

Child's Name:____ ❑Male ❑Female

Date of Birth:(MM/DD/YY)____

Mailing Address:____

City:______________________Prov:__________Postal Code:____________

Home Phone:______________________Cell Phone:__________________

Emergency Phone:____

Who accompanied the child today?:______________________________

Do you have legal custody of the child?: ❑YES ❑NO

How did you hear about Southdown Dental?

❑Family/Friend ❑Sign ❑Physician__________________________

❑Other (Please Specify) ____

Primary Insurance

Subscriber:_____________________________

DOB:(MM/DD/YY)________________________

Employer:______________________________

Ins Company:___________________________

Policy Group Plan #:_____________________

Contract ID/Subscriber ID #:______________

Secondary Insurance

Subscriber:_____________________________

DOB:(MM/DD/YY)________________________

Employer:______________________________

Ins Company:___________________________

Policy Group Plan #:_____________________

Contract ID/Subscriber ID #:______________

PARENTS/GUARDIANS INFORMATION

Name:____

Marital Status:____

Date of Birth (MM/DD/YY):___________________________________

Relationship to child:_______________________________________

Lives with child:_____________________________________ ❑YES ❑NO

Mailing Address:____

Employer:____

Work Phone:____

Home Phone:____

Cellular:____

E-mail Address:____

DENTAL HISTORY

Why did you bring your child to us today? ____

Is this your child's first visit to the dentist? ❑ YES ❑ NO

If no: Previous Dentist: ____

Date of last visit: ____

Were any x-rays taken? ❑ YES ❑ NO

Has your child had any problems with previous dental care? ____

How do you expect your child to cooperate for dental treatment? ____

Does your child currently have a toothache? ❑ YES ❑ NO

Child's Name:____

Have there been any injuries to your child's teeth? ❑ YES ❑ NO

If yes, explain: ____

Is the water your child drinks fluoridated? ❑ YES ❑ NO ❑ DON'T KNOW

How often are your child's teeth being brushed? _______________ Flossed? _______________ By whom? _______________

MEDICAL HISTORY

Name of pediatrician or family physician: ____

Is your child currently taking any medication or drugs? ❑ YES ❑ NO

If yes, state why and list: ____

____

Has your child ever had a bad reaction to drugs, including antibiotics or local/general anesthetics? ❑ YES ❑ NO

If yes, explain: ____

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Has your child ever had surgery or been hospitalized? ❑ YES ❑ NO

If yes, explain: ____

____

Are antibiotics required prior to dental treatment? ❑ YES ❑ NO

Does your child have or ever been diagnosed with any of the following conditions (please check):

- ❑ None
- ❑ AIDS/HIV
- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Autism
- ❑ Bleeding Disorder
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Cleft Lip/Palate
- ❑ Developmental Delays
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Eye Problems
- ❑ Hearing Loss
- ❑ Heart Disease/Murmur
- ❑ Hepatitis
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mentally Challenged
- ❑ Rheumatic/Scarlet Fever
- ❑ Seizures
- ❑ Sickle Cell Anemia
- ❑ Speech Problems
- ❑ Tuberculosis
- ❑ Other: _______________

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Is there anything else we should know about your child's health or medical conditions? ❑ YES ❑ NO

If yes, explain: ____

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I certify that I have read and understand the above questions. If I had questions about this form, they were answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in completing this form.

___________________________	_________________	______________________________
Parent/ Guardian Signature	MM/DD/YY	Dentist Signature