Family Dentistry of Caledonia
Child Patient Information/ Medical History

IF THE CHILD IS UNDER 18 YEARS OF AGE, WE EXPECT A PARENT OF GUARDIAN TO REMAIN IN THE OFFICE FOR THE CHILD'S ENTIRE VISIT. Today's Date :_____

Child's Name :_____
(last) (first) (middle initial) (preference)

Child's Home Address :_____

City, State, Zip :_____

Child's Home Phone :(_____)_____Cell Phone :(____)_____

Birth Date :_____ Age :_____ Sex :_____ Social Security Number :_____

Family Email address: _____ Child's School: _____

PARENT'S INFORMATION: Marital Status :_____

Mother **Step Mother** **Guardian**

Name :_____ Birth Date :_____

Address :_____

City, State, Zip :_____

Home Phone # :(_____)_____ Work # :(_____)_____

Cell Phone :(_____)_____ Social Security # :_____

Employer :_____ Length of Employment :_____

Drivers License # :_____

Father **Step Father** **Guardian**

Name :_____ Birth Date :_____

Address :_____

City, State, Zip :_____

Home Phone # :(_____)_____ Work # :(_____)_____

Cell Phone :(_____)_____ Social Security # :_____

Employer :_____ Length of Employment :_____

Drivers License # :_____

PERSON RESPONSIBLE FOR ACCOUNT:

Name :_____ Relationship :_____

Billing Address :_____

City, State, Zip :_____

Home Phone # :(_____)_____ Work # :(_____)_____

Cell Phone :(_____)_____ Social Security # :_____

Employer :_____ Length of Employment :_____

Drivers License # :_____

Who is accompanying the child today?

Name :_____ _____ Relationship :_____

Do you have legal custody of this child ? Yes No Is the child adopted? Yes No

Is the child in a foster home? Yes No

Other siblings seen by us :_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

HEALTH

Is the child under the care of a physician? Yes No Explain :_____

Child's Physician :_____ Phone # :(_____)_____

Please describe the child's current physical health : Good Fair Poor Are immunizations current? Yes No

Has the child had/ experienced any of the following:

Y	N	Artificial Bones/ Joints/ Valves	Y	N	Asthma/ Tuberculosis (TB)
Y	N	HIV/AIDS	Y	N	Cancer
Y	N	Diabetes	Y	N	Chicken Pox
Y	N	Blood Transfusion	Y	N	Convulsions/ Epilepsy
Y	N	Congenital Heart Defect	Y	N	Handicaps/ Disabilities Type:_____
Y	N	Heart Murmur	Y	N	Hearing Impairments
Y	N	Heart Surgery	Y	N	Hive/ Skin Rash
Y	N	High/ Low Blood Pressure	Y	N	Kidney Problems
Y	N	Mitral Valve Prolapse	Y	N	Lupus
Y	N	Hepatitis/ Liver Disease/ Jaundice	Y	N	Measles
Y	N	Rheumatic/ Scarlet Fever	Y	N	Mononucleosis
Y	N	Abnormal Bleeding/ Aspirin Use	Y	N	Sickle Cell Anemia/ Anemia
			Y	N	Tonsillitis

Has the child ever been hospitalized for any reason? _____

Is the child allergic to any of the following?

Y	N	Motrin (Ibuprofen)	Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Clindamycin	Y	N	Penicillin

Additional Allergies :_____

Please list all medications that the child is currently taking (prescribed or over the counter)

_____

Does/ did the child have any of the following habits?

Y	N	Clenching on Objects	Y	N	Speech Problems
Y	N	Clenching / Grinding Teeth	Y	N	Thumb/ Finger Sucking
Y	N	Lip Sucking/ Biting	Y	N	Tongue Thrust
Y	N	Nursing Bottle Habits			
		Y N Used Pacifier			

DENTAL HISTORY

Is the child currently in pain?	Y	N	
Has the child ever had any pain/ tenderness in his/ her jaw joint?	Y	N	
Has the child experienced problems with previous dental work?	Y	N	
Is the child's water fluoridated?	Y	N	
Is the child taking fluoridated supplements?	Y	N	
Does the child brush his/ her teeth daily?	Y	N	How many times? _____
Floss his/ her teeth daily?	Y	N	How many times?_____

Previous/ Present Dentist :_____ Date of last visit :_____

Why did you leave previous dentist?_____

What did you like most about any dentist you have seen?_____

Least about?_____

What is the primary reason for today's visit?_____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGE IN MY MEDICAL STATUS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO FOR PAYING ANY CO-PAY AND DEDUCTIBLE THAT MY DENTAL BENEFIT DOES NOT COVER ON THE DATE OF SERVICE.
DUE TO THE INCREASED NUMBER OF BROKEN APPOINTMENTS THERE WILL BE A CHARGE OF $50.00 PER ½ HOUR OF APPOINTMENT TIME BILLED TO YOUR ACCOUNT FOR MISSED APPOINTMENTS WITHOUT 48 HOURS NOTICE. WE WILL TRY TO CONFIRM APPOINTMENTS THE DAY PRIOR TO YOUR SCHEDULED TIME. WHEN YOU MAKE AN APPOINTMENT IT IS YOUR RESPONSIBILITY TO KEEP IT. HOWEVER, IF WE CANNOT REACH YOU OR YOU DO NOT GET THE MESSAGE, THE APPOINTMENT IS STILL YOUR RESPONSIBILITY.

Signature :_____ Date :_____ Relationship :_____