**.....TO BE COMPLETED BY THE PERSON AUTHORIZED TO TAKE DECISIONS REGARDING DENTAL TREATMENT FOR THIS MINOR.....**

** DATE_____

## 1. Tell us about your child:

Name: _____
Last First M. I.
Nickname_____ Female or Male
Age_____ Birthdate_____
Interests:_____

Physical and Mailing Address:
_____
_____
Tel #: Home:_____
Mobile_____
Mobile:_____
E-mail:_____

## 1. Family Information:

Father's Name_____
Biological Parent/ Stepfather / Legal Guardian (Please Circle)
DOB: _____SS #:_____
Employer_____
Work #: _____

Mother's Name_____
Biological Parent/ Stepmother/ Legal Guardian (Please Circle)
DOB_____ SS #: _____
Employer_____
Work #: _____
Marital Status of Parents_____
*Is the child adopted? Yes or No * If Yes, Please give details:_____
_____
*Is the child aware of been adopted? Yes or No
Who has legal custody of this child? Adoptive Parents/
Other: Explain_____
_____

Emergency Contact: Name/ Tel #:_____
_____
_____

## 3. Concerns Regarding Your child's teeth:

Date/Place of Last Dental Exam:_____
Were X-rays Taken? Yes or No
Injuries to the teeth face or mouth in the past? Yes or No
Please explain_____
_____
_____

Habits: Yes or No: (Thumb sucking for example)
If Yes, please explain:_____
_____

Updated_____

## 4. Health History:

ALLERGIES:_____
_____

(Please circle) How would you describe the child's overall health?
Excellent Good Poor
*Is the child under Medical Treatment? If yes, Please explain:
_____
_____

Has the child ever had any of the following conditions?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | N | Blood Disorders | Other Medical Condition | | | | |
| Y | N | Allergies to any Drug | | | Y | N | Hearing Impairment |
| Y | N | Any Hospital Stay | | | Y | N | Heart Murmur |
| Y | N | Any Operations | | | Y | N | Hemophilia |
| Y | N | Asthma | | | Y | N | Hepatitis |
| Y | N | AUTISM | | | Y | N | HIV+/ AIDS |
| Y | N | ADD/ ADHD | | | Y | N | Kidney/Liver Condition |
| Y | N | Congenital Heart Problem | | | Y | N | Radiation treatment |
| Y | N | Convulsions/Epilepsy | | | Y | N | Rheumatic fever |
| Y | N | Cancer/ Chemotherapy | | | Y | N | ALLERGY TO LATEX |
| Y | N | Handicap/ Disability | | | | | |

Please explain details/ dates:
_____
_____
_____

Is your child receiving any kind of therapy?
Explain:_____
_____
_____

Please list Medications the child is Taking:

_____ _____
_____ _____
_____ _____

Have you been told that the child should take Antibiotics Before Dental Treatment? Yes or No

Please list Medications that Child is Allergic to:

_____ _____
_____ _____
_____ _____
Child's weight: _____lbs/ kg
Name of Pediatrician_____
***Telephone #_____

## 5. Insurance Information: Complete!!!!

DEROS_____
Insurance Co. Name_____
Tel #:_____
Policy Owner's Name_____
SS# or Policy Number_____
Employer_____
_____