Name_____
Child's Last Name First Name Preferred Name Middle Initial

Responsible Guardian's Name: _____

Address_____

City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ (For contacting you regarding our appointments only).

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Text Message

Birthdate_____ Gender: ☐ M ☐ F

Social Security #_____ (optional unless needed for insurance ID#)

Emergency Contact _____ Best Contact Number _____

How did you hear about our office?

☐ Driving by/Neighborhood
☐ Internet Search
☐ Online Source:_____
☐ Yellow Pages/Advertisement/Flyer
☐ Insurance Source
☐ Someone you know_____
☐ Given a card/pen
☐ Former Patient
☐ Other_____

Medical History

Check if your child has reactions or allergies to any of the following:

☐ Anbesol
☐ Epinephrine
☐ Penicillin/Amoxicillin
☐ Benzodiazepines (Valium, Halcion, Versed, Ambien)
☐ Erythromycin/Clindamycin
☐ Sulfa Drugs
☐ Latex
☐ Codeine/Hydrocodone
☐ Nitrous Oxide
☐ Other_____

Check if your child has or has had any of the following:

☐ AIDS/HIV Positive
☐ Anemia or Blood Disorder
☐ Arthritis, Rheumatism or other Inflammatory Disease
☐ Artificial Joints _____
☐ Asthma
☐ Cancer or Tumor
☐ Depression
☐ Diabetes
☐ Emphysema or other Respiratory Illness
☐ Epilepsy
☐ Fainting or Dizzy Spells
☐ Glaucoma
☐ Hepatitis (A, B, or C)
☐ Herpes
☐ High BP, Last BP Reading:____/_____ (ex: 170/90)
☐ High Cholesterol
☐ Osteoporosis
☐ Pacemaker
☐ Radiation or Chemotherapy
☐ Surgeries and/or Hospitalizations
☐ Tuberculosis
☐ Heart Condition: Bacterial Endocarditis
☐ Heart Valve (Artificial) or Heart Transplant
☐ Heart Murmur (Mitral Valve Prolapse)
☐ Heart Stent, Date: _____
☐ Heart Disease, Heart Attack, Heart Surgery Date:_____

☐ Pregnant, Due Date: _____ ☐ Nursing ☐ Taking Birth Control Pills (Women Only)

Has your physician instructed your child to take medication prior to his/her dental visit? ☐ Y ☐ N
If yes, what medication? _____ For what condition?_____
Is your child currently under physician care? ☐ Y ☐ N If yes, describe _____
Physician Name_____ Number_____ Date of Last Visit _____

Please list all medications your child is currently taking and corresponding conditions (include over the counter medications, herbs and supplements).

Medication **Condition**

_____

_____

_____

_____

_____

Recreational drugs can interfere with your dental health. The anesthetics and/or medications we may use during your treatment can have adverse reactions with recreational drugs. Please inform us before treatment if you have used any recreational drugs within a week of your appointment.

Dental History

What are your interests for your child's visit today? _____

Is there anything that concerns you about your child's mouth/teeth/gums/smile?_____

Last Dental Visit _____ **Last Cleaning** _____ **Last Dental X-Rays**_____

Check if your child is experiencing any of the following:

- ☐ **Bad Breath**
- ☐ **Bleeding/Sore Gums**
- ☐ **Broken Fillings/Teeth**
- ☐ **Clicking or Popping of Jaw**
- ☐ **Food Collection Between Teeth**
- ☐ **Grinding or Clenching of Teeth**
- ☐ **Loose Teeth**
- ☐ **Periodontal Treatment**
- ☐ **Sensitivity to Cold, Location:** _____
- ☐ **Sensitivity to Hot, Location:** _____
- ☐ **Sensitivity to Sweets, Location:**_____
- ☐ **Sensitivity when Biting, Location:**_____
- ☐ **Sores, Ulcers or Bumps in Mouth**

Does your child use an electric toothbrush? ☐ **Y** ☐ **N**

Are you interested in whitening your child's teeth? ☐ **Y** ☐ **N**

Has your child ever experienced an adverse reaction during a medical or dental procedure ☐ **Y** ☐ **N**

If yes, please describe:_____

Is there any additional information about your child's dental health or previous treatment we should be aware of?

_____

Authorization

I have reviewed the information that I have provided on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment and is completely confidential. If there is any change in my medical status I will inform the dentist. I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Guardian's Signature_____**Date**_____

Acknowledgement of Receipt of Notice of Privacy and Security Practices

I, _____ have received a copy of this office's Notice of Privacy and Security Practices.

Please Print Name of Patient (Child)

Signature of Guardian_____ **Date**_____

For Office Use Only

Restoration Dental attempted to obtain written acknowledgement of receipt of our Notice of Privacy and Security Practices, but acknowledgment could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining acknowledgement

_____An emergency situation prevented acknowledgement

_____Other: _____