Child Form: Patient Information

Date_______________

Name of child/minor ____
Last First Middle Initial

Sex: Male ___ Female___ Age____ DOB _________Nickname_________ Hobbies____________

Home Address:____

____

School Name: ____

Parent/Guardian:____

Home Phone:__________________ Cell Phone____________________ E-mail:_______________________

How do you wish patient's appointment to be confirmed:

Text_____ Phone_____ E-mail_____ Voicemail_____

Preferred Appointment Time: AM_____ PM_____

In case of emergency, who should be notified:____

Person financially responsible for child/minor's treatment:__________________________________

Whom may we thank for referring you to our office?

Website_____ Another patient_____ School_____ Radio_____ Yellow Pages_____
Google/Bing_____ Facebook_____ Other____

Dental History

(please circle the appropriate response)

Date of last visit to dentist _______________ For what service?_____________________________________

Is child currently under the care of a physician for any illness? Yes No

____

Has child complained about dental problems? Yes No
Does child brush teeth daily? Yes No
Does child use floss every day? Yes No
Is fluoride taken in any form? Yes No
Any injuries to mouth, teeth, or head? Yes No
Any unhappy dental experiences? Yes No
Does child grind teeth at night? Yes No
Any mouth habits- thumbsucking, nailbiting, mouthbreathing, sleeping with bottle? Yes No