Patient Information (Please print in ink)

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip Code _____ Phone Number _____

Social Security # _____ Date of Birth _____ Age _____ Male _____ or Female _____ Preferred Language _____

School _____ Grade _____ Optional Information (for statistical purposes only): Race/Ethnicity _____

Patient Health History (Please answer all questions)

ADHD (Attention Deficit Hyperactivity Disorder)	Yes __ No __	Use of Diet Pills/Diet Aids (including Phen-Fen)	Yes __ No __	Kidney or Liver Disease	Yes __ No __
Alcohol/Drug Abuse	Yes __ No __	Disabilities/Special Needs	Yes __ No __	Pregnant	Yes __ No __
Allergies	Yes __ No __	Epilepsy	Yes __ No __	Prosthetic Joints, Plates or Pins	Yes __ No __
Anemia	Yes __ No __	Fainting	Yes __ No __	Rheumatic Fever	Yes __ No __
Asthma/Breathing Problems	Yes __ No __	Heart Murmur	Yes __ No __	Sickle Cell Anemia	Yes __ No __
Autism	Yes __ No __	Heart Trouble	Yes __ No __	Speech/Hearing Problems	Yes __ No __
Birth Defect(s)	Yes __ No __	Hepatitis	Yes __ No __	Has the patient had surgery?	Yes __ No __
Bleeding/Clotting Problems	Yes __ No __	High Blood Pressure	Yes __ No __	Tobacco Use	Yes __ No __
Diabetes	Yes __ No __	HIV/AIDS	Yes __ No __	Tuberculosis	Yes __ No __

If you answered "Yes" to any of the above, please explain:

_____

_____

Yes ____ No ____ Does the patient have any other health problems? If "Yes", please explain _____

_____

Yes ____ No ____ Is the patient taking any medications at this time (including over-the-counter medications such as aspirin)?
If "Yes", what type: _____

_____

Yes ____ No ____ Is the patient allergic to any medications? If "Yes," what?: _____

_____

Yes ____ No ____ Is the patient allergic to anything else? If "Yes", what (for example: latex, anesthesia)?: _____

_____

Yes ____ No ____ Does the patient have any dental problems/concerns at this time? If "Yes, please explain: _____

_____

Parent/Guardian Information (Please Print)

Mother/Guardian Name _____ Father/Guardian Name _____ Parent/Guardian Email Address _____

Address _____ City _____ Zip Code _____ (____)_____ Home Phone # (____)_____ Cell or Work Phone #

Nearest Relative Not Living With Patient _____ Relationship to Patient _____ (____)_____ Phone #

Please List Other Siblings Seen At This Center: _____

Patient's Pediatrician/Family Physician _____ (____)_____ Patient's Pediatrician/Family Physician's Phone # _____ Signature of Dentist

Pursuant to an agreement with the Office of Inspector General of the United States Department of Health and Human Services, this Dental Center maintains a list of substantiated incidents of patient harm over the last eighteen months, which is available for your review upon request.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I consent for the examination, teeth cleaning, application of topical fluoride, any necessary x-rays and clinical photographs, and any necessary sealants.

Parent/Guardian Signature _____ Date _____