All Star CHILDREN'S DENTISTRY

Patient Information
Name: _____
DOB: _____ Age: _____ Sex: M or F
Address: _____
City: _____ State: _____ Zip: _____

EMAIL ADDRESS; mom dad _____

Pharmacy and location: _____

PARENT/GUARDIAN INFORMATION:
Father: Stepfather Guardian Other _____

Name: _____ DOB: _____ SS# _____

Address: (if different from child) _____

Place of Employment: (if military a unit address is mandatory) _____ Work # _____

Home Telephone # _____ Cell # _____
Mother: Stepmother Guardian Other _____

Name: _____ DOB: _____ SS# _____

Address: (if different from child) _____

Place of Employment: (if military a unit address is mandatory) _____ Work # _____

Home Telephone # _____ Cell # _____

INSURANCE: Name of Insurance policy: _____
Do you have more than one insurance policy for your child? Yes No
If yes, please provide name of secondary insurance: _____

DENTAL HISTORY:
Why is your child here today? _____
Is this your child's first visit to the dentist? _____ If no, when was the last visit? _____
Will your child be a cooperative patient? _____

Please describe how your child will behave today. Circle all that apply:
Friendly Happy Timid Afraid Resistant

Does your child receive fluoride in any form? _____ If yes, what kind? _____
Has your child inherited any dental characteristics? _____
Have there been any injuries to your child's teeth? _____
Has your child had any of the following problems? Circle All that apply:
Cavities Toothache Bad Breath Crooked Teeth Sensitive to Sweets
Bleeding Gums Sensitive to Hot/Cold Frequent Headaches
Discolored Teeth Loose Teeth Teeth Bumped TMJ Popping/Clicking Jaw Pain

Does your child have any of the following oral habits?
Thumb Sucking Lip Biting Teeth Grinding PacifierUse

How often does your child brush their teeth? _____ Floss? _____
At what age did your child stop using the bottle? _____ Sippy Cup? _____ Still nursing? _____

MEDICAL HISTORY

Child's Physician_____

Address _____ Phone # _____

Is your child in good general health? Yes No

If no, please describe _____

Does your child have any physical disabilities/developmental delays? Yes No

If yes, please describe _____

Are your child's immunizations and booster shots up to date? Yes No

Has your child had any surgical operations? Yes No

If yes, for what? _____

Has your child ever been hospitalized? Yes No

If yes, for what? _____

Has your child had or does he/she now have:

1. Allergies **YES or NO**
   - Latex Allergies **YES or NO**
   - Seasonal Allergies _____
   - Food Allergies _____
   - Drug Allergies _____

2. Has your child had any history of asthma or breathing problems? _____
   - Has your child been to the ER for an asthma attack? _____
   - What induces the breathing problems? _____
   - What asthma medication does your child take? _____

PLEASE CIRCLE YES/NO TO ALL CONDITIONS LISTED BELOW

3. Autism Spectrum	Yes No	14. Hearing/Vision Impairment	Yes No	25. Steroids therapy or chemotherapy	Yes No
4. Sensory Integration Issues	Yes No	15. Eating disorders	Yes No	26. Nervous or emotional disorders	Yes No
5. ADD/ADHD	Yes No	16. Abnormal Bleeding or bruising	Yes No	27. Convulsions or seizures	Yes No
6. Heart Trouble or heart murmur	Yes No	17. Prolonged Bleeding /Transfusions	Yes No	28. Date of last seizure _____	
7. Rheumatic heart disease or fever	Yes No	18. Birth Defects	Yes No	29. Frequent diarrhea or vomiting	Yes No
8. Blood diseases or anemia	Yes No	19. Kidney Disease	Yes No	30. Mumps, measles, or chickenpox	Yes No
9. AIDS virus	Yes No	20. Cleft lip or palate	Yes No	31. Cancer, tumors, growths or cysts	Yes No
10. Herpes virus or shingles	Yes No	21. Scarlet fever or high fever	Yes No	32. Sinus problems or drainage	Yes No
11. Diabetes	Yes No	22. High or low blood pressure	Yes No	33. Tuberculosis or TB exposure	Yes No
12. Ear, eye, nose or throat trouble	Yes No	23. Liver disease	Yes No	34. Problems with Anesthesia	Yes No
13. Stomach ulcers	Yes No	24. Jaundice or hepatitis	Yes No	35. Thyroid disease	Yes No

CURRENT MEDICATIONS:

Name/Strength (mg)	How often?	Reason taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Does your child have problems with any of the following? Speech Hearing Vision Sleep

Do you consider your child to be? Advanced in learning Progressing normally A slow learner

Child's first language? _____ Second or other languages? _____

Is your child adopted? Yes No If yes, at what age? _____

How does your child tolerate dental/medical care? _____

Child's favorites (pet, toy, color, friend, hobby etc.) _____

Authorization and Release:

I understand that payment of a calculated % is due at the time treatment is rendered, and that my dental insurance carrier may pay less then the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during period of such dental care to third party payers' and/or health practitioners.

Signature of Parent/Guardian: _____ Printed Name: _____

Date: _____