

The following information is necessary for us to provide the best possible treatment for you child.
Please respond completely to all questions.

Patient's full name _____ Prefers to be called _____ Age _____
 Sex _____ Race _____ Date of birth _____ Place of birth _____
 Patient's street address _____ City _____ State _____ Zip _____
 Patient's Social Security # _____ Home phone (_____) _____
 Father's name _____ Date of birth _____ Social Security # _____
 His street address _____ City _____ State _____ Zip _____
 Phone (_____) _____ Where employed? _____ Phone (_____) _____
 Father's dental insurance _____ Address _____ Policy # _____
 Mother's name _____ Date of birth _____ Social Security # _____
 Her street address _____ City _____ State _____ Zip _____
 Phone (_____) _____ Where employed? _____ Phone (_____) _____
 Mother's dental insurance _____ Address _____ Policy # _____
 Phone numbers for appointment confirmation/reminder _____
 With whom does patient live? _____
 Medicaid? Yes No Children's Special Health Services _____ Other _____
 Patient's physician _____ Family dentist _____
 How did you learn about us? Doctor Parent Patient Phone book Referring person's name _____
 _____ Address _____ City _____ State _____ Zip _____

Health history

	Yes	No	Please check any that pertain to your child	
Is your child in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Asthma
Does your child have regular medical exams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lung problem	<input type="checkbox"/> Allergies
Are your child's immunizations current?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Brain injury	<input type="checkbox"/> Mental disability
Is your child presently taking medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Liver problem	<input type="checkbox"/> Mental disorder
Please list _____			<input type="checkbox"/> Kidney problem	<input type="checkbox"/> Emotional disorder
Any history of allergic reaction to medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous disorder
Please list _____			<input type="checkbox"/> Diabetes	<input type="checkbox"/> Autism
Is your child undergoing any medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Speech disorder
Please explain _____			<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Hearing disorder
Has your child been hospitalized since birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> Vision disorder
Date _____ Reason _____			<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____
List any infectious diseases _____				

Other information

	Yes	No		Yes	No
Is this your child's first dental visit?	<input type="checkbox"/>	<input type="checkbox"/>	Is your child a finger sucker?	<input type="checkbox"/>	<input type="checkbox"/>
If no, date of last dental care _____			Does your child use a pacifier?	<input type="checkbox"/>	<input type="checkbox"/>
Any unfavorable experiences in a dental office?	<input type="checkbox"/>	<input type="checkbox"/>	Was your child bottle fed? Until age _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a toothache?	<input type="checkbox"/>	<input type="checkbox"/>	Was your child breast-fed? Until age _____	<input type="checkbox"/>	<input type="checkbox"/>
Purpose of today's appointment _____					
What is your water source? <input type="checkbox"/> Private well <input type="checkbox"/> Public system			Name of public system _____		
Thank you for your help. If there is any additional information that you think might be of value to us in treating your child, please feel free to comment: _____					

I agree to diagnostic procedures and dental treatments as found necessary and desirable by Randall J. Pagenkopf, D.M.D. for the patient named above. I do also authorize and request the administration of such anesthesia /sedatives as may be deemed advisable by the above named doctor. I am aware that I will be informed of all services before any treatment is rendered to my child. I will accept responsibility for this account should named party fail or insurance benefit be denied. Date _____ Signature _____
 Email: _____