DENTISTRY FOR CHILDREN

Dr. Culberson R. Boren, DDS, PA

PATIENT INFORMATION

Child's Name:_____ Child's Soc. Sec #:_____

Prefers to be called:_____ Age:_____ Date of Birth:_____ Sex: ☐ M ☐ F

Person Financially Responsible:_____ Relationship To Child:_____

How did you hear about our office? ☐ Internet ☐ TV ☐ Community Event ☐ Family Member ☐ Friend ☐ Doctor ☐ Other_____

Whom may we thank for referring you?_____

PARENT / LEGAL GUARDIAN INFORMATION

FATHER / Legal Guardian

Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

E-Mail:_____

Soc. Sec #:_____ Date of Birth:_____

Employer:_____

Does this person have insurance on the child? ☐ Yes ☐ No

If yes, name of Insurance Company:_____

Does this person live in the child's home? ☐ Yes ☐ No

MOTHER / Legal Guardian

Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

E-Mail:_____

Soc. Sec #:_____ Date of Birth:_____

Employer:_____

Does this person have insurance on the child? ☐ Yes ☐ No

If yes, name of Insurance Company:_____

Does this person live in the child's home? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Child's Pediatrician:_____ Phone:_____

Previous Dentist:_____ Date of last visit:_____

What other immediate family members have we seen (example: siblings of the patient)?_____

I have been introduced to or met: ☐ Dr. Boren ☐ Dr. Le ☐ Dr. Ming ☐ Dr. Rice ☐ I have not met any of the dentists at Dentistry for Children

Nearest relatives not listed above:

Name:_____ Relationship to child:_____ Phone:_____

Name:_____ Relationship to child:_____ Phone:_____

<CONTINUED ON REVERSE SIDE>

MEDICAL HISTORY

Has the child had any history of, or conditions related to, any of the following:

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	HIV / AIDS	☐	☐	Pregnant?	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Kidney	☐	☐	Rheumatic Fever	☐		Other:_____
☐	☐	Bleeding Disorders	☐	☐	Fainting	☐	☐	Latex Allergy	☐	☐	Seizures	☐		Other:_____
☐	☐	Cancer	☐	☐	Hearing	☐	☐	Liver	☐	☐	Sickle Cell	☐		Other:_____
☐	☐	Cerebral Palsy	☐	☐	Heart	☐	☐	Measles/Mumps	☐	☐	Speech Problems	☐		Other:_____
☐	☐	Cleft Lip or Palate	☐	☐	Hepatitis	☐	☐	Mononucleosis	☐	☐	Tobacco/Drug Use?			

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list the name, dosage and frequency of each:_____	1. ☐	☐
2. Is the child allergic to any medications? If yes, please list:_____	2. ☐	☐
3. Is the child allergic to anything else such as foods, dyes, latex? If yes, please list:_____	3. ☐	☐
4. Has the child ever had a serious illness? If yes, please explain:_____	4. ☐	☐
5. Has the child ever been hospitalized? If yes, please explain:_____	5. ☐	☐
6. Has the child ever had surgery or been put to sleep? If yes, please list any problems with general anesthesia:_____	6. ☐	☐
7. Is the child currently under the care of any special care doctors (heart, neuro, gastro, etc.)? If yes, please provide the Doctor's name, specialty, and contact phone number:_____	7. ☐	☐
8. Is the child physically, mentally or emotionally impaired? If yes, please explain:_____	8. ☐	☐
9. Does the child experience excessive bleeding when cut?	9. ☐	☐

DENTAL HISTORY

	Yes	No
10. Is this the child's first visit to the dentist?	10. ☐	☐
11. Has the child had any problems with dental treatment in the past? If yes, please describe:_____	11. ☐	☐
12. Has the child ever had any injuries to the mouth, head or teeth? If yes, please describe:_____	12 . ☐	☐
13. Has the child ever had a local anesthetic (numbing medicine)?	13. ☐	☐
14. Has your child ever had a bad/unfavorable dental experience? If yes, please explain:_____	14. ☐	☐
15. Does your child have a toothache, oral pain, or any other dental complaints? If yes, please explain:_____	15. ☐	☐

16. Please list any mouth habits (thumb sucking, mouth breathing, etc.):_____

17. What is the reason for today's dental visit?_____

Please list any other dental/medical problems, dental/medical concerns, and provide any other information you think may be important in the care of your child: _____

I certify that I have read and understand the above and that any questions I had while filling out this form have been answered to my satisfaction. I will not hold the dentists or any other member of the staff at Dentistry for Children responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

PRINTED NAME OF PARENT OR LEGAL GUARDIAN | SIGNATURE OF PARENT OR LEGAL GUARDIAN

_____ _____

RELATIONSHIP TO PATIENT | DATE