Child Personal and Health Questionnaire

Name:____ (Nick Name)__________ S.S.N._______-_____-____________
Gender: **M** or **F** D.O.B:____________ Age:______
Home Address:________________________________ City:_____________ State:__________ Zip Code:__________
Home Phone:(_____)______-__________ Mobile Phone:(_____)______-_________ Email:____________________________
Mother's Full Name:____________________________ Father's Full Name:_______________________________________
How did you hear about our office:_______________________Name of school:_________________
Preferred Appointment Days: Mo: ◯am ◯pm Tu: ◯am ◯pm We: ◯am ◯pm Th: ◯am ◯pm Fr: ◯am ◯pm

Medical History

Have you ever been treated for: (Please circle **Y** for YES and **N** for NO)

Y / N	Endocrine Problem	Y / N	Prolonged Bleeding	Y / N	Hepatitis	Y / N	Diabetes	Y / N	Arthritis
Y / N	Nervous Disorder	Y / N	Heart Problems	Y / N	Cancer	Y / N	Liver Problems	Y / N	Asthma
Y / N	Rheumatic Fever	Y / N	Bone Disorder	Y / N	Fainting	Y / N	Birth Defects	Y / N	AIDS/HIV

Y / N Allergies: (Please list)_______________ Other conditions not listed:___________________________
Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?______ If so, which one:________________ Other medication(s):__________________________________
Are you under the care of a physician?_______________ If yes, why?____

Dental History

Y / N Have you had prior orthodontic treatment?
Y / N Have there been any injuries to the face, mouth or teeth
Y / N Do you have any problems with speech?
Y / N Have you been informed of any missing teeth?
Y / N Are any of your teeth sensitive or sore?
Y / N Do you have any cavities not filled?
Y / N Do you have any gum problems?

TMJ History

Y / N Do you clinch and grind your teeth?
Y / N Has the jaw ever locked or slipped out of place?
Y / N Do you have frequent headaches?
Y / N Do you have pain or ringing in the ears?
Y / N Have you experienced any discomfort or clicking of the jaw

General Dentist:_____________________ Last Dental Cleaning:_________ How often do you brush:______ Floss______
Dentist's Address:______________________________ City:_____________ State:__________ Zip Code:__________

Parent(Guardian) Information

Full Name:____________________ Relationship to Pt:________________ Gender: M or F D.O.B:_____
Home Address:________________________________ City:_____________ State:__________ Zip Code:__________
Home Phone:(_____)______-__________ Mobile Phone:(_____)______-_________ Work Phone:(_____)______-__________
SSN:_______-_____-_______ Email:____
Marital Status:_________________ Spouse's Full Name:____
Employer:____________________ Occupation:______________________ Number of years employed:____________

Primary Dental Insurance Information **Do you have another Dental Insurance Policy for this child?** ◯**Yes** ◯**No**

Policy Holder's Full Name:_________________________ SSN:_______-_____-____ D.O.B:______
Insurance Company:___________________________ Policy ID:________________ Group Number:___________
Insurance Company's Phone Number:(_____)______-_________ Second Phone Number:(_____)______-__________
Insurance Company Address:____________________ City:_____________ State:__________ Zip:_______________
Employer:____
Employer's Address:___________________________ City:_____________ State:__________ Zip Code:__________
Relationship to patient:_______________________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform the office of any changes to my child's medical status. If the office accepts my insurance, I am responsible for payment of any co-payment, deductibles or any fees that my insurance does not cover.

Parent/Guardian Signature:_______________________________________ Date:_______________________________