



Today's Date: _____

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services for your child. To assist us in serving you, please complete the following form. The information provided on this form is important to your child's dental health. If you have any questions, do not hesitate to ask.

Child's Name: _____ Preferred Name: _____

Date of birth: _____ Age: _____ Gender: MALE FEMALE

School: _____ Grade: _____

Child's Home Address: _____ Child's Home Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible for Child's Account: _____ Relationship to Child: _____

Address: _____ Name of Employer: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary dental insurance: _____	Group #: _____
Subscriber's Name: _____	Date of birth: _____ SS#: _____
Secondary dental insurance: _____	Group #: _____
Subscriber's Name: _____	Date of birth: _____ SS#: _____

Name of your child's medical doctor: _____

Is your child under the care of a physician now? _____

If so, for what reason? _____

Please list daily medications: _____

MEDICAL HEALTH HISTORY

Has your child ever had the following? (Please circle yes or no)

Allergies to latex	YES	NO	Heart Murmurs	YES	NO
Allergies to penicillin	YES	NO	High Blood Pressure	YES	NO
Allergies to other medicines	YES	NO	HIV (AIDS)	YES	NO
Please list below:			Hepatitis	YES	NO
_____			Implants (joint, heart, valves, etc)	YES	NO
Asthma	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Stroke	YES	NO
Epilepsy	YES	NO	Tendency to bleed	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO
Premedication required by physician	YES	NO			

If yes, please explain: _____

DENTAL HEALTH HISTORY

Is your child apprehensive about dental treatment?	YES	NO
Does your child have any pain associated with teeth?	YES	NO
Does your child clench or grind his/her jaws frequently?	YES	NO
Does your child experience pain in his/her jaw?	YES	NO

Name of previous dentist: _____ Date of last visit: _____

How did you hear about Greenway Dental Care? _____

I understand the information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I also understand that I am responsible for payment of services rendered, and for paying any co-payment and deductible that my insurance does not cover.

Signature: _____ Date: _____