Freeman Family & Cosmetic Dentistry

PATIENT INFORMATION

NAME [LAST] [FIRST] [MIDDLE] [PREFERS TO BE CALLED]				SOCIAL SECURITY NUMBER - -
PRESENT ADDRESS [STREET, CITY, STATE, ZIP CODE]				HOME TELEPHONE ( )
BIRTHDATE [MM-DD-YYYY]	AGE	SEX M F	E-MAIL	
GENERAL DENTIST		LAST VISITED [MM-DD-YYYY]		HOBBIES
ATTENDS SCHOOL AT:			GRADE	
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE				

PARENTS INFORMATION

FATHER

NAME [LAST] [FIRST] [MIDDLE]				SOCIAL SECURITY NUMBER - -
PRESENT ADDRESS [STREET, CITY, STATE, ZIP CODE]				HOME TELEPHONE ( )
BIRTHDATE [MM-DD-YYYY]	AGE	E-MAIL		WORK TELEPHONE ( ) ext.
EMPLOYER	OCCUPATION		NO. YEARS EMPLOYED	CELL TELEPHONE ( )

MOTHER

NAME [LAST] [FIRST] [MIDDLE				SOCIAL SECURITY NUMBER - -
PRESENT ADDRESS [STREET, CITY, STATE, ZIP CODE]				HOME TELEPHONE ( )
BIRTHDATE [MM-DD-YYYY]	AGE	E-MAIL		WORK TELEPHONE ( ) ext.
EMPLOYER	OCCUPATION		NO. YEARS EMPLOYED	CELL TELEPHONE ( )

Medical History

Child's Physician:_____ Date of last visit_____

Is the child currently under the care of a physician? Yes No

If yes, please explain: _____

Please list all medications that the child is currently taking: _____

Please list all medications / foods / other that cause the child allergic reactions:

_____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding	Y N Blood Transfusion	Y N Cancer
Y N Anemia	Y N Asthma	
Y N AIDS/HIV+	Y N Any Hospital Stays/Surgeries	
Y N Cerebral Palsy	Y N Cleft Palate / Lip	Y N Diabetes
Y N Epilepsy / Seizures	Y N Handicaps / Disabilities	Y N Hearing / Speech
Y N Heart Disease	Y N Heart Murmur	Y N Hepatitis Type__
Y N High / Low Blood Pressure	Y N Hives	Y N Kidney Problems
Y N Liver Problems	Y N Rheumatic Fever	Y N Sickle Cell
Y N Tuberculosis (TB)		

What is the ***primary*** reason for today's visit?

_____

Is your child currently having problems with any of the following?

Cavities	Toothache	Gum Infection	Color of Teeth
	Sensitive Teeth	Tooth Alignment	Trauma

Does the child brush his / her teeth daily with fluoride toothpaste? Yes No
Do you give the child any other form of fluoride? Yes No
Does the child floss his / her teeth daily? Yes No
Was your child bottle / breast-fed? Yes No
Does your child suck a finger / thumb / pacifier / or exhibit any other habits? Yes No
Has your child experienced fears with previous dental work? Yes No

Date of last Visit: _____

Signature _____ Date _____

Relationship to Child _____