Alpha Dental Associates

PATIENT INFORMATION

Today's Date: _____

Name of the patient: _____ Nick Name: _____

Patient's Date of Birth: _____ Sex: Male ☐ Female ☐

Father's Name: _____ Mother's Name _____

SS#: _____ SS#: _____

Date of Birth: _____ Date of Birth: _____

Home address: Street _____

City _____ State _____ Zip _____

Home Telephone #: _____

Parent's occupation: Mother: _____ Cell # _____ Work Phone #: _____

Father: _____ Cell # _____ Work Phone #: _____

Physician's Name: _____ Telephone #: _____

Previous Dentist Name: _____ Telephone #: _____

Is the child adopted or living with someone other than the natural parents? If yes, comment _____

_____

List any brothers or sisters (name and age) _____

_____

_____

Is this patient's 1st dental visit? Yes No

If no, name, address and phone number of previous dentist _____

_____

1. Whom may we thank for referring you to us? Name _____

Yellow Pages ☐ Newspaper ☐ Friend ☐ Other ☐

PRIMARY CARRIER		
EMPLOYEE NAME:		EMPLOYEE SS #:
EMPLOYEE DOB:	EMPLOYER NAME:	
PLAN NAME:	GROUP #:	
INSURANCE CO. NAME:		
INSURANCE CO. ADDRESS		
SECONDARY CARRIER		
EMPLOYEE NAME:		EMPLOYEE SS #:
EMPLOYEE DOB:	EMPLOYER NAME:	
PLAN NAME:	GROUP #:	
INSURANCE CO. NAME:		
INSURANCE CO. ADDRESS		

Is the child taking supplemental fluoride? ..... YES NO

DENTAL AND MEDICAL HISTORY: (Please circle YES or NO where indicated)

1) Has the child had any unusual or unpleasant experiences in a dental or medical office? ..... YES NO
2) Has the child had any injuries to the face, mouth or teeth? ..... YES NO
3) Has the child ever had a toothache? ..... YES NO
4) Does the child have any oral habits such as thumbsucking? ..... YES NO
5) Does the child have any health problems? ..... YES NO
6) Is the child presently under the care of a physician? Except for check up visits ..... YES NO
7) Has the child been in a hospital or had surgery? ..... YES NO
8) Is the child taking any medications at this time? ..... YES NO
9) Has the child missed any immunization shots? ..... YES NO
10) Where there any problems during pregnancy, delivery or during the child's first year of life? .... YES NO
11) Has the child had an unusual reaction or allergy to medications such as penicillin, aspirin or local anesthetics? ..... YES NO
12) Does the child have a history of any allergies? ..... YES NO
13) Does the patient suffer from:

Excessive or prolonged bleeding	YES	NO	Asthma	YES	NO
High blood pressure	YES	NO	Liver Disease	YES	NO
Kidney Disease	YES	NO	High Fevers	YES	NO
Rheumatic Fever	YES	NO	Tonsillitis	YES	NO
Ear Infections	YES	NO	Dizziness	YES	NO
Fainting	YES	NO	Anemia	YES	NO
Diabetes	YES	NO	Hepatitis	YES	NO
Tuberculosis (TB)	YES	NO	Nutritional Problem	YES	NO
Behavior Problems	YES	NO	Convulsions (seizures)	YES	NO
Cancer or tumors	YES	NO	Vision Problems	YES	NO
Speech Problems	YES	NO	Blood Transfusions or Products	YES	NO
Hearing Problems	YES	NO	X-ray Treatment	YES	NO
Birth Defects	YES	NO	AIDS or HIV	YES	NO
Sickle Cell Diseases or trait	YES	NO	Any special problem not listed		
Heart trouble or murmur	YES	NO	above?	YES	NO

14) Please describe any current medical treatment, including drugs, pending surgery, recent injuries or any other information the doctor should be aware of: _____

_____

_____

_____

Please check which one of the following best describes the patient:

Advanced in the learning process ☐
Progressing normally in the learning process ☐
A slow learner ☐

Does the child attend a special class or school? ☐

Please check all words which seem best to describe the patient:

Calm	☐	High-strung	☐	Spoiled	☐	Active	☐
Cooperative	☐	Moody	☐	Suspicious	☐	Fearful	☐
Defiant	☐	Shy	☐	Talkative	☐	Compulsive	☐
Friendly	☐	Sickly	☐	Temper Tantrums	☐	Healthy	☐

If the patient has pets, hobbies, or special interests, list them giving the name and type of pet(s).

I hereby give consent to Dr. _____ and his staff to perform on _____ those procedures and treatments including local anesthesia and/or conscious sedation which are deemed necessary with exception of_____.
I have been informed there are some risks inherent in all dental procedures including the administration of local anesthesia and in the administration of drugs common to dental practice (for example, possible allergic reaction to anesthetic or drug, possible accidental cuts or abrasions). I further consent to necessary Xrays, study models, photographs and accepted behavior modification techniques.

FINANCIAL AGREEMENT

I understand that I am responsible for the cost of dental treatment for myself or my dependents, due and payable at the time of service unless financial arrangements are made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (we) promise to pay legal interest on the account together with a responsible counsel and/or collection costs which shall total 33 1/3% of the balance due and owing Alpha Dental Associates on the open account.

Parent Signature_____ (Relation to patient:_____) Date:_____

Dr's Signature_____

Explanation of Medical History

Emergency Treatment Record
Date:

Comments on Medical History

Emergency Tx Record