Minor Patient Information (under 18 Years of Age)

Date _____/_____/_____

Child's Name: Last:_____ First:_____ Middle I:_____

I prefer to be called:_____ M: ____ F: _____ Other: ____

Child's Address: _____ City:_____ State:____ Zip:_____

Home Phone #: _____ Child's Cell#:_____

Child's Birthdate: ____/____/_____ School: _____ Grade: _____

Whom may we thank for referring you to our office? **_____**

Parent/Guardian Information

Mother's Name: Last:_____ First: _____ Cell#:_____

Email:_____ SS#:_____-____-_____ Birthday:_____/_____/_____

Mailing Address: _____ City:_____ State:____ Zip:_____ Apt#:____

Father's Name: Last:_____ First: _____ Cell#:_____

Email:_____ SS#:_____-____-_____ Birthday:_____/_____/_____

Mailing Address: _____ City:_____ State:____ Zip:_____ Apt#:____

Dental Insurance Information (Y / N)

Primary Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Insured's Name:_____ Relationship to patient: _____

Does Patient have Dual Coverage? Yes ____ No ____ (If Yes fill out Secondary Insurance)

Secondary Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Insured's name:_____ Relationship to patient: _____

Dental History

Why have you come to the dentist today?_____

Are you currently in pain? _____ Do you experience bleeding gums? _____

How often do you brush your teeth? _____ Do you floss your teeth? Y_____N_____

How many times a week? _____Do you feel your teeth are sensitive? _____

Have you experienced pain or noise coming from your jaw/TMJ joint? _____

Are you aware of clenching or grinding your teeth? _____

Have you had any injuries to your face, mouth, or teeth? _____

Tobacco Use? If so, what kind and how much? _____

Former Dentist_____ City/State_____