STUDIO CITY DENTAL GROUP®

Patient ID _____

PATIENT INFORMATION – CHILD FORM

Tell us about your child

Child's Name _____ _____
Last First Middle Preferred Name

☐ Male ☐ Female Birth Date: _____ Age: _____

Address: _____ How long at this Address: _____
City Zip

Home Phone: (_____)_____ Hobbies _____

School _____ Grade: _____

Patient or Parent Email: _____

Name & ages of sibling Patients: _____

Previous Dentist: _____ Last visit date: _____

Address: _____ Phone#: (_____)_____

Do you have any dental concerns? _____

Whom may we thank for referring you? _____

Parent Information — Responsible Party: ___ Yes ___ No

Name _____ Relation _____ Birth Date: _____
Work Phone #: (_____)_____ Home Phone #: (_____)_____
Employer: _____ Job Title: _____
How long at current job: _____ SS#: _____ DL#: _____

Parent Information — Responsible Party: ___ Yes ___ No

Name _____ Relation _____ Birth Date: _____
Work Phone #: (_____)_____ Home Phone #: (_____)_____
Employer: _____ Job Title: _____
How long at current job: _____ SS#: _____ DL#: _____

Parent(s)Marital Status

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Person (NOT living with you) to contact in case of emergency:

Name _____ Relation _____ Phone: (_____)_____

Primary Dental Insurance

Insurance Co. name: _____
Policy owner's name: _____
Policy owner's birthdate: _____
Policy owner's SS#: _____

Secondary Dental Insurance

Insurance Co. name: _____
Policy owner's name: _____
Policy owner's birthdate: _____
Policy owner's SS#: _____

Dental History

Any injuries to head or mouth? _____ Any jaw clicking, locking or pain? _____

Has child ever had orthodontic treatment or worn a retainer or bite plate: ☐Yes ☐ No

Please check YES or NO to any of the following conditions that apply to your child:

Y	N	(please check)	Y	N	(please check)	Y	N	(please check)
☐	☐	Baby teeth removed	☐	☐	Frequent cold sores, canker sores	☐	☐	Root canals
☐	☐	Chipped/Injured teeth	☐	☐	Grinding teeth or clenching	☐	☐	Sensitivity to cold/heat
☐	☐	Cyst/Infection	☐	☐	Jaw fractures	☐	☐	Teeth irritating cheek/lips
☐	☐	Dental Treatment in progress	☐	☐	Missing teeth	☐	☐	Thumb habit to age _____
☐	☐	Difficulty breathing/chewing	☐	☐	Mouth breathing	☐	☐	Tongue habit
☐	☐	Food impaction	☐	☐	Periodontal problems/bleeding gums	☐	☐	Any permanent or extra teeth removal

Medical History

Physician _____ Phone: (_____)_____ Last visit: _____

Please list all medications your child is currently taking (or has taken in the past 5 years) _____

_____

Are there any psychological or emotional problems that should be brought to our attention: _____

Does your child need to be pre-medicated? ☐Yes ☐ No Why: _____

(Females) Is the patient: Pregnant or think she may be? ☐Yes ☐ No Allergies: _____
(Foods / Medications / Latex Gloves / Unknown)

Has your child ever been hospitalized? ☐ Yes ☐ No Explain: _____

Please check YES or NO to any of the following conditions that apply to your child:

Y	N	(please check)	Y	N	(please check)	Y	N	(please check)
☐	☐	Rheumatic Fever/heart disease	☐	☐	Tuberculosis (TB)	☐	☐	Developmental disability
☐	☐	Congenital heart disease (i.e. murmur)	☐	☐	Persistent cough, cough up blood	☐	☐	Abnormal bleeding associated with previous surgery, extractions or accidents
☐	☐	Cardiovascular disease	☐	☐	Epilepsy			
☐	☐	Asthma	☐	☐	Sickle Cell disease	☐	☐	Required a blood transfusion
☐	☐	Fainting spells or seizures	☐	☐	Emphysema	☐	☐	Blood disorders (i.e. anemia)
☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Psychological treatment	☐	☐	Surgery, x-ray or chemotherapy for tumor growth or other condition
☐	☐	Diabetes	☐	☐	Cerebral palsy			
☐	☐	Arthritis	☐	☐	Mental retardation	☐	☐	AIDS
☐	☐	Stomach ulcers	☐	☐	Hearing Disability	☐	☐	ADD / ADHD
☐	☐	Kidney trouble						

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand that, if necessary, credit bureau reports may be obtained.

It is my responsibility to advise the office of any changes in personal/medical status: Parent's initials _____

Please sign that this information is accurate and complete:

Signature _____Relationship _____ Date _____

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, or problems we may encounter? ☐Yes ☐ No

Updates

I have reviewed my child's Patient Information form and have made any necessary changes.

Signature _____Relationship _____ Date _____

Signature _____Relationship _____ Date _____

Signature _____Relationship _____ Date _____