ROCKWALL
DENTAL ASSOCIATES

DATE _____

TELL US ABOUT YOUR CHILD		
Name		
Social Security #		
Gender	MALE	FEMALE
Date of Birth		
Age		
Home Address		
Phone Number		

PRIMARY DENTAL INSURANCE		
Employer		
Name of Policy Holder		
Policy Holder Date of Birth		
Policy Holder SS#		
Relationship to Patient		
Insurance Co. Name		
	ID #	Group #
	Phone #	
Insurance Co. Address		

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DENTAL ASSOCIATES

FATHER'S INFORMATION	
Name	
Social Security #	
Date of Birth	
Email	
Home Address	
Phone Number	

MOTHER'S INFORMATION	
Name	
Social Security #	
Date of Birth	
Email	
Home Address	
Phone Number	

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DENTAL ASSOCIATES

DENTAL HISTORY	
Previous Dentist	
Previous Dentist Address	
Date of Last Dental Visit	
Were X-Rays Taken	YES / NO If so, what type?
Has your child injured head, mouth, or teeth	YES / NO Please Explain
Is your child's water fluoridated?	YES / NO
Does your child take fluoride supplements?	YES / NO
Has your child had difficulty with previous dental visits?	YES / NO Please Explain
Are you aware of any problems with your child's mouth or teeth?	YES / NO Please Explain
Has your child ever pre-medicated for dental treatment?	YES / NO Please Explain
Comments/Questions	

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DENTAL HISTORY (CONFIDENTIAL)

Does your child have a history of, or is your child currently doing any of the following?

Pacifier	☐ Yes	☐ No
Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Was your child	☐ Yes	☐ No
Bottle Fed	☐ Yes When weaned:	☐ No
Breast Fed	☐ Yes When weaned:	☐ No

MEDICAL HISTORY (CONFIDENTIAL)

Physician's Name: Phone #:

Date of Last Visit:

Previous Hospitalizations/ Surgeries/ Serious Illnesses: When?

Had a Blood Transfusion	☐ Yes When:	☐ No
Are immunizations up to date	☐ Yes	☐ No
Is your child taking any Medications:	☐ Yes Which Ones:	☐ No
Is your child Allergic to any medications?	☐ Yes Which Ones:	☐No
Has your child ever developed any condition including bleeding, drug or anesthesia reaction or rash requiring special treatment after your last dental visit?	☐ Yes Please Explain:	☐No

HEALTH HISTORY (CONFIDENTIAL)

Does your child have a Blood Disorder? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Anemia	☐ Yes		Von Willebrand	☐ Yes	
Hemophilia	☐ Yes		Sickle Cell	☐ Yes	
Excessive Bleeding	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have a Heart Condition? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Artificial Valve	☐ Yes		High Blood Pressure	☐ Yes	
Congenital Heart Defect	☐ Yes		Low Blood Pressure	☐ Yes	
Heart Disease	☐ Yes		Heart Attack (Myocardial Infarction)	☐ Yes	
Heart Murmur (Irregular Heart Beat)	☐ Yes		Pacemaker	☐ Yes	
Rheumatic Fever	☐ Yes		Infective Endocarditis	☐ Yes	
Angina (Chest Pains)	☐ Yes		Mitral Valve Prolapse	☐ Yes	

If you answered yes to any of these, please explain: _____

Does your child have a Respiratory Diseases/ Lung Disorder? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Asthma	☐ Yes		Persistent Cough	☐ Yes	
Breathing Difficulty	☐ Yes		Shortness of Breath	☐ Yes	
COPD	☐ Yes		Sleep Apnea	☐ Yes	

If you answered yes to any of these, please explain: _____

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Cont. HEALTH HISTORY (CONFIDENTIAL)

Does your child have Special Needs? ☐ Yes ☐ No If you chose yes, please check the box that apples.

ADHD	☐ Yes		Wheelchair	☐ Yes	
Behavior Disorder	☐ Yes		Hearing Impairment	☐ Yes	
Autism	☐ Yes		Head Injury	☐ Yes	
Depression	☐ Yes		Developmental Challenges	☐ Yes	
Down Syndrome	☐ Yes		Nervous Disorders	☐ Yes	
Cerebral Palsy	☐ Yes		Psychological Disorders	☐ Yes	
Vision Impairment	☐ Yes		Bipolar Depression	☐ Yes	
Spina Bifida	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have an Infectious Disease? ☐ Yes ☐ No If you chose yes, please check the box that applies.

HIV/AIDS	☐ Yes		STD	☐ Yes	
Hepatitis	☐ Yes		Tuberculosis	☐ Yes	
Herpes	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have Stomach Problems? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Reflux	☐ Yes		Ulcers	☐ Yes	

If you answered yes to any of these, please explain: _____

Does your child have Ear Problems? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Ear Tubes	☐ Yes		Recurrent Ear Infections	☐ Yes	
Hearing Loss	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have/ had Cancer? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Chemotherapy	☐ Yes		Remission	☐ Yes	How Long?
Radiation	☐ Yes		Leukemia	☐ Yes	
Tumors	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have history of any of the conditions listed below? ☐ Yes ☐ No If you chose yes, please check the box that applies.

Arthritis/Rheumatism	☐ Yes		Liver Disease	☐ Yes	
Cleft Palate	☐ Yes		Pregnancy	☐ Yes	What Trimester: ____
Diabetes	☐ Yes		Seizures	☐ Yes	
Dialysis	☐ Yes		Sinus Problems	☐ Yes	
Epilepsy	☐ Yes		Stroke	☐ Yes	
Dizziness/Fainting	☐ Yes		Tobacco Use	☐ Yes	
Joint Replacement	☐ Yes		Drug Use	☐ Yes	
Kidney Disease	☐ Yes		Eating Disorder	☐ Yes	
Thyroid Disorder	☐ Yes		Skin Rash	☐ Yes	
			Artificial Joint	☐ Yes	

If you answered yes to any of these, please explain: _____

Does your child have anything that has not been previously mentioned? ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

SIGNATURE OF LEGAL GUARDIAN _____DATE_____