FAMILY
DENTISTRY

Today's Date: ______________

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services for your child. To assist us in serving you, please complete the following form. The information provided on this form is important to your child's dental health. If you have any questions, do not hesitate to ask.

Child's Name: ____ Preferred Name: _______________________________

Date of birth: ____________________ Age:____________ Gender: MALE FEMALE

School:______________________________ Grade:_________

Child's Home Address: ___________________________________ Child's Home Phone:_______________________________

City:__________________ State: ______ Zip: _____________

Person Responsible for Child's Account: ______________________ Relationship to Child:______________________________

Address:____ Name of Employer:_______________________________

City:_________________ State:_______ Zip:_____________ Social Security #:_________________________________

Home Phone:_______________________ Work Phone: _______________________ Cell Phone: _______________________

Primary dental insurance: _______________________________________ Group #:___________________________

Subscriber's Name:________________________ Date of birth: _________________ SS#:______________________

Secondary dental insurance: _____________________________________ Group #:___________________________

Subscriber's Name:________________________ Date of birth: _________________ SS#:______________________

Name of your child's medical doctor: _____________________

Is your child under the care of a physician now? ________________

If so, for what reason? ____

Please list daily medications:____

MEDICAL HEALTH HISTORY

Has your child ever had the following? (Please circle yes or no)

Allergies to latex	YES	NO	Heart Murmurs	YES	NO
Allergies to penicillin	YES	NO	High Blood Pressure	YES	NO
Allergies to other medicines	YES	NO	HIV (AIDS)	YES	NO
Please list below:			Hepatitis	YES	NO
____			Implants (joint, heart, valves, etc)	YES	NO
Asthma	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Stroke	YES	NO
Epilepsy	YES	NO	Tendency to bleed	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO

Premedication required by physician YES NO

If yes, please explain: ____

DENTAL HEALTH HISTORY

Is your child apprehensive about dental treatment? YES NO

Does your child have any pain associated with teeth? YES NO

Does your child clench or grind his/her jaws frequently? YES NO

Does your child experience pain in his/her jaw? YES NO

Name of previous dentist: ____________________________________ Date of last visit: __________________________________

How did you hear about Keech Family Dentistry? ____

I understand the information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I also understand that I am responsible for payment of services rendered, and for paying any co-payment and deductible that my insurance does not cover.

Signature: ____ Date:_____________________