Patient Information and Health History

Child's Information:

First Name: ______________ **Last Name:** ______________ **SSN:** ______________
Age: ______________ **Date of Birth:** ______________ **Sex:** Male or Female
School District: ______________ **School:** ______________ **Grade:** ______________
Child's Street Address: ______________________________
City: ______________ **State:** __________ **Zip:** __________
Child Lives with: (Circle) Father Mother Both Other: _____
Marital Status of Parents: (Circle) Married Single Divorced Separated Widowed
How did you hear about us? (Circle)
Building Sign Internet Search Facebook Event: __________ Friend: __________ Doctor/Dentist: __________
Pets: ______________ **Favorite Shows:** ______________
Child's Siblings and Their Ages: ______________________________

Parent/Guardian(s) Information:

Father/Self/Guardian Name: ______________
Date of Birth: ______________
Social Security Number: ______________
Street Address: ______________
City: ______________ **State:** _____ **Zip:** _____
Home Phone: __________ **Work Phone:** __________
Cell Phone: __________ **E-mail:** __________
Employer: ______________
Emp. Street Address: ______________
Emp. City: ______________ **State:** _____ **Zip:** _____
Employer Phone Number: ______________
Ins. Company: ______________
Ins. ID #: ______________
Ins. Group #: ______________
Has your child received previous dental care under this plan? (Circle) Yes No

Mother/Guardian Name: ______________
Date of Birth: ______________
Social Security Number: ______________
Street Address: ______________
City: ______________ **State:** _____ **Zip:** _____
Home Phone: __________ **Work Phone:** __________
Cell Phone: __________ **E-mail:** __________
Employer: ______________
Emp. Street Address: ______________
Emp. City: ______________ **State:** _____ **Zip:** _____
Employer Phone Number: ______________
Ins. Company: ______________
Ins. ID #: ______________
Ins. Group #: ______________
Has your child received previous dental care under this plan? (Circle) Yes No

Emergency Contact Information:

Emergency Contact Name: ______________ **Phone:** ______________

Child's Physician Contact Information:

Name: ______________ **Date Last Seen:** ______________
Practice Name: ______________ **Phone Number:** ______________
Street Address: ______________________________
City: ______________ **State:** __________ **Zip:** __________

History:

Is your child being treated by a Physician at this time? Yes or No **If yes, why?** ________________

Has your child ever been a patient in a hospital? Yes or No **If yes, why?** ________________

Has your child ever received general anesthesia or sedation? Yes or No **If yes, when?** ________________

Is your child allergic to anything (food or medicine)? Yes or No **If yes, what?** ________________

Is your child taking any medication at this time? Yes or No **If yes, what?** ________________

Has your child ever been seen by a dentist before? Yes or No

Date Last Seen: __________ Dentist's Name: ____________ **X-rays Taken?** Yes or No

Has your child ever received fluoride in any form? Yes or No **If yes, what?** ________________

Does your child suck his/her thumb or fingers? Yes or No

Are your child's teeth brushed once or more a day? Yes or No

Organs and Systems:

Has this child ever had treatment for any of the following? Please check all that apply.

- ☐ Blood Circulatory
- ☐ Blood Transfusion
- ☐ Bones
- ☐ Endocrine Glands
- ☐ Eyes, Ears, Nose, Throat
- ☐ Gastrointestinal-Stomach
- ☐ Kidney-Bladder
- ☐ Heart
- ☐ Heart murmur
- ☐ Liver
- ☐ Muscles
- ☐ Nervous System
- ☐ Respiratory-Lungs
- ☐ Skin
- ☐ Tonsils-Adenoids

Illness:

Has this child ever been diagnosed as having any of the following conditions? Please check all that apply.

- ☐ AIDS
- ☐ Anemia
- ☐ Allergy
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Brain Injury
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Cleft Lip-Palate
- ☐ Convulsions-Seizures
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Drug or Alcohol Abuse
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis Type ________
- ☐ Jaundice
- ☐ Leukemia
- ☐ Measles
- ☐ Mental Retardation
- ☐ Mumps
- ☐ Mouth Breathing
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnancy
- ☐ Psychiatric Disorder
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Snoring at night
- ☐ Sore Throats-frequent
- ☐ Spina Bifida
- ☐ Syndrome __________
- ☐ Tetanus
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Latex Allergy
- ☐ ADD-ADHD
- ☐ Disorders __________

Other:

Is there anything else that you think we should know about your child?

____

____

____

Consent:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment. I will not hold Iannessa Pediatric Dentistry, PC, Christina Iannessa, DMD, or any member of their staff responsible for any errors or omissions I may have made in this form.

I authorize Christina Iannessa, DMD and/or such associates or hygienists and/or assistants as she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor(s) or other individual(s) for which I have responsibility, now and in the future, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of the treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child/children or ward(s). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

______________________________ ______________________________ __________________

Signed Name Printed Name Date