New Patient Registration & Health Questionnaire — Youth

*We are pleased to welcome you and your child to our dental practice. We promise to do our best to provide you with the finest care available. Please take a few minutes to fill out this **confidential** form as best as you can. Correct dental and medical history information is essential for this office to provide individual and appropriate care to meet your dental needs safely and efficiently.*

Name of Minor/Child_____ Age _____ Birth date _____

Home Address _____ Phone_____

_____ Cell # _____
city state zip

Sex ☐ Male ☐ Female S. S. #_____ Hobbies _____

Names of Parents or Guardian _____ _____

Names of other children in household _____ _____ _____ _____

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

In the event of an emergency, whom should we contact?_____

Relationship to Patient_____ Phone #'s_____ _____

Person responsible for this account_____

If you have dental insurance, Who is the insured?_____Group #_____

Name of the Insurance company_____

Ins. Co. Address_____Phone #_____

☐ If you have a secondary insurance please inform our desk of the name, address, group # and phone #.

Dental History

1. Is this your first dental visit? ☐ No ☐ Yes When was your last dental visit?_____
2. Have you had any trouble with previous dental treatment?_____
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. How often do you brush your teeth?_____ Does anyone help you? ☐ No ☐ Yes
5. How often do you have professional dental cleanings?_____
6. Check (√) if you have any of the following:
   - ❑ Complaints about any dental problems (pain, sores, swelling, broken teeth, missing teeth)
   - ❑ Mouth habits (nail biting, thumb sucking, clenching or grinding, pacifier, sleeping with bottle)
   - ❑ Take Fluoride regularly, in any form
   - ❑ Injuries to your mouth, teeth or head
   - ❑ Any unhappy dental experiences? Explain_____

Medical History

1. Name of Physician_____ Date of last visit_____
2. Physicians address_____ Phone #_____
   Street City
3. Do you see your physician regularly for a particular condition? ☐ No ☐ Yes

   Explain_____
4. Have you ever been hospitalized for a serious illness or operation? ☐ No ☐ Yes

   Explain_____
5. Have you ever had excessive bleeding from a cut? Or do cuts take a long time to heal? ☐ No ☐ Yes

6. Place a check (√) to indicate if you have any history of or difficulty with any of the following?

- ❑ Heart problems
- ❑ Mitral Valve Prolapse
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ Bleeding disorders
- ❑ Anemia
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Respiratory problems
- ❑ Asthma
- ❑ Diabetes
- ❑ Cancer
- ❑ Tuberculosis
- ❑ Mononucleosis
- ❑ AIDS / HIV positive
- ❑ Hepatitis, type_____
- ❑ Chicken Pox
- ❑ Measles or Mumps
- ❑ Eye disorders
- ❑ Hearing problems
- ❑ Sinus problems
- ❑ Allergies
- ❑ Thyroid disease
- ❑ Convulsions / Seizures
- ❑ Fainting / Dizziness
- ❑ Bladder problems
- ❑ Drug or Alcohol abuse
- ❑ Attention disorders
- ❑ Others_____ _____

Comments_____

_____

MEDICATIONS? ☐ None

_____

_____

_____

ALLERGIES? ☐ None

_____

_____

_____

Is there any disease, condition or problem not listed above that you think we should know about? ☐ No ☐ Yes

Explain_____

It is important that at each dental visit minors are accompanied by a parent / guardian or responsible person over 18 years of age.

To the best of my knowledge, all of the preceding answers are true and correct and any changes in the health status of this patient will be reported to this office at the earliest possible time.

Permission to release health information: I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers and/or other health practitioners only if relating to my dental needs.

Person completing this form_____Date_____
Signature

If other than the patient, indicate relationship _____

Reviewed health questionnaire with the patient, parent/guardian_____
Signature – Doctor / Hygienist