

Acquaintance Form

Date: _____

We sincerely welcome you and your child into our practice. We will make your dental visits as pleasant as we can. In order for us to better understand your child, please complete this form as thoroughly as possible. Thank you.

Child's Name: _____ Nickname: _____ Sex: M F
 Age: _____ Date of Birth: _____ Weight: _____ School: _____
 Name of Siblings (*circle those we have treated*): _____
 Physician: _____ Date of last medical examination: _____
 Names of Child's Favorites (*pet, toy, friend, etc.*): _____
 Whom may we thank for referring you to our office? (*If referred by a patient, please indicate*): _____
 What is your main concern for this visit? _____

Dental Insurance Carrier: _____ **Address:** _____ **Phone:** _____
Insured's Name: _____ **Date of Birth:** _____ **Social Security Number:** _____

Medical History

Is your child in good health? Yes No

Has your child had or does he/she have now:

	YES	NO		YES	NO
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	Emotional, mental or nervous problems	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip or palette.	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Food or pollen allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction to medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____			Epilepsy or any seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Is your child taking any medication now?	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____			Prolonged bleeding or hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with speech	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or malignancies	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Mouth injuries	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or lung problems	<input type="checkbox"/>	<input type="checkbox"/>			

Dental History

Is this your child's first visit to our office? Yes No
 Has your child been seen in any other dental office? Yes No
 If so, where? _____

Date of last dental exam: _____ Date of last X-rays: _____
 Has your child experienced any unfavorable reaction from any previous medical or dental care? (*State which*) _____

Does your child have any mouth habits such as finger sucking? Yes No If so, what? _____
 Does your child brush every day? Yes No Do you assist with brushing or flossing? Yes No
 Is your child still breast or bottle feeding? Yes No

Family Dentist: _____
 Father's complete name: _____ Soc. Sec.# _____ Dri. Lic. # _____
 Home Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
 Mother's complete name: _____ Soc. Sec. # _____ Dri. Lic. # _____
 Home Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
 Are parents divorced, separated, remarried, or deceased? Yes No If yes, please explain: _____
 Father's Place of Employment: _____ Phone: _____
 Mother's Place of Employment: _____ Phone: _____
 Name of person to contact in case of emergency (*not living at home*): _____
 Address: _____ Phone: _____

In order to provide your child with optimum care, we draw upon the knowledge of our entire staff of doctors in consulting, diagnosis and treatment of all patients. The undersigned hereby authorizes this dental office to perform the examination and, after explanation, the necessary dental services deemed appropriate for the care of the above named child and furthermore, will be responsible for charges incurred from said dental patient.

Parent Signature: _____ Date: _____