Core Dental Health

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General Information: DATE:_____

Child's Name:_____ Sex:_____ Age:_____

Child's Preferred Name:_____ Date of Birth:_____

Social Security:_____ Child's Medical Doctor:_____

Family Dentist:_____

Email Address:_____

Father:_____ Date of Birth:_____ Social Security:_____

Address:_____

City:_____ State:_____ Zip:_____

Employed By:_____ Work Phone:_____

Home:_____ Cell:_____

Mother:_____ Date of Birth:_____ Social Security:_____

Address:_____

City:_____ State:_____ Zip:_____

Employed By:_____ Work Phone:_____

Home:_____ Cell:_____

Dental Insurance?_____ Primary_____ ID#_____

Secondary_____ ID#_____

Person Responsible for the Account: Father ⬜ Mother ⬜
Who has Legal Custody of the Child: Father ⬜ Mother ⬜

Child's Dental History:

Date of child's last dental visit:_____

Dentist child was last seen by:_____

Does your child have a tooth that hurts now? Yes ⬜ No⬜

Reason for Visit:_____

Do you have any specific concerns?_____

_____.

Child's Health History:

Is your child in good health? Yes ⬜ No ⬜

Date of last Medical Doctors Exam:_____

Has your child ever been in the hospital? Yes ⬜ No ⬜

If so, please explain:_____

Is your child up to date with immunizations (shots)? Yes ⬜ No ⬜

Is your child presently taking any medications?

Please List_____ _____

_____ _____

_____ _____

_____ _____

Is your child allergic to any medications? Yes ⬜ No ⬜

If so please list_____

Is the patient pregnant? Yes ⬜ No ⬜ Are you taking contraceptives? Yes ⬜ No ⬜

Medical Conditions:

____Down Syndrome ____ADD/ADHD

____Heart Condition ____Cerebral Pasy ____Tuberculosis

____Rheumatic Fever ____Autism ____Hepatitis

____Liver Disorder ____Emotional Disorder ____Asthma

____Kidney Disorder ____Mental Disorder ____Diabetes

____Lung Problems ____Nervous Disorder ____Stomach Problems

____Brain Damage ____Bleeding Disorder ____Cancer/Tumors

____Epilepsy ____Speech Disorder ____Hearing Disorder

____Vision Disorder ____Acuired Immune Deficiency Syndrome

Do you have any artificial joints? Yes ⬜ No ⬜

Since _____is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all necessary dental services can be performed by Dr. Ellsworth and his staff. Authorization is hereby granted as such. Furthermore, I will be responsible for any bill incurred on this patient for dental treatment.

Signed_____ Date:_____

Relationship_____