Core Dental Health

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GENERAL INFORMATION: Date: ____________________

Child's Name: ____________________ Name child goes by: ____________________ Sex: ________ Age: ________

Date of Birth: ____________________ Child's Medical Doctor: ____________________ Family Dentist: ____________________

Father: ____________________ Address: ____________________ (Street, City, State, Zip) S.S.# ____________________

Employed by: ____________________ Work Phone: ____________________ Home Phone: ____________________

Mother: ____________________ Address: ____________________ (Street, City, State, Zip) S.S.# ____________________

Employed by: ____________________ Work Phone: ____________________ Home Phone: ____________________

Person responsible for account: Father________ Mother________ Other________ Cell Phone: *(Father)* ____________________

Who has legal custody of child: Father________ Mother________ Other________ Cell Phone: *(Mother)* ____________________

Email: ____________________

Dental Insurance?: ________ Co. ____________________ # ____________________

Co. ____________________ # ____________________

Who referred you to us, so we may thank them? ____________________

CHILD'S HEALTH HISTORY:

Is your child in good health? ____________________ Date of last medical doctor's exam: ____________________

Has your child ever been in the hospital? ________ Explain: ____________________

Is your child up to date with immunizations (shots)? ____________________

Is your child presently taking any medications? ________ List: ____________________

____

Is your child allergic to ANY medications? ________ List: ____________________

____

Check any of the following that may pertain to your child:

____ Acquired Immune Deficiency Syndrome; ARC;AIDS
____ Latex
____ Heart Condition
____ Epilepsy (Seizures)
____ Downs Syndrome
____ Bleeding Disorder
____ Rheumatic Fever
____ Tuberculosis
____ Cerebral Palsy
____ Speech Disorder
____ Liver Disorder
____ Hepatitis
____ Autism
____ Hearing Disorder
____ Kidney Disorder
____ Asthma
____ Emotional Disorder
____ Vision Disorder
____ Lung Problems
____ Diabetes
____ Stomach Problems
____ Mental Disorder
____ Allergies
____ Brain Damage
____ Cancer/Tumors
____ Nervous Disorder
____ Other

CHILD'S DENTAL HISTORY:

Date of child's last dental visit ____________________

Dentist child was last seen by: ____________________ City: ____________________

Does your child suck their thumb or finger? ____________________ Use pacifier? ____________________

At what age was your child weaned from the bottle? ____________________

Does your child have a tooth that hurts now? ____________________

Reason for this visit: ____________________

Do you have any specific concerns? ____________________

PERMISSION:

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 financially for any bill incurred on this patient for dental treatment.

Signed: ____________________ Date: __________ Relationship: ____________________