

# CHILD'S QUESTIONNAIRE

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Birth Date \_\_\_\_\_  
Age \_\_\_\_\_ Nick-name \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_  
Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

**Mother's Information:** Name \_\_\_\_\_  Mother  Stepmother  Legal Guardian  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**Father's Information:** Name \_\_\_\_\_  Father  Stepfather  Legal Guardian  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Do you have dental insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

## PRIMARY INSURANCE

Subscriber Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Carrier/Group Number \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

## SECONDARY INSURANCE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

Is this your child's first visit to a dentist?  Yes  No

If no, how long ago was the last visit and for what treatment? \_\_\_\_\_

Does your child have any painful areas or sensitive teeth or gums in their mouth at this time?  Yes  No

Describe: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Are other members of the child's immediate family also patients with our office? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

How often are your child's teeth brushed? \_\_\_\_\_ By whom? \_\_\_\_\_

Does your child:  use fluoride rinses  take fluoride tablets/drops  brush with fluoride gel

Does your child suck their:  thumb  finger  lip ( ) ( )

Are you interested in having sealants on your child's teeth? ..... ( ) ( )

Does your child have any speech problems? \_\_\_\_\_ ( ) ( )

Describe: \_\_\_\_\_

**MEDICAL HISTORY**

Has your child been under a physician's care or hospitalized within the last year?..... ( ) ( )

Reason \_\_\_\_\_

Is your child currently taking any prescription or non prescription medication? ..... ( ) ( )

List \_\_\_\_\_

Is your child allergic to any medication? ..... ( ) ( )

List \_\_\_\_\_

Does your child have any general allergies? List \_\_\_\_\_ ( ) ( )

Has your child ever had a reaction to a local/dental anesthetic? ..... ( ) ( )

Has your child had an unfavorable reaction to nitrous oxide (laughing gas)? ..... ( ) ( )

Does your child bleed easily, or of long duration when cut? ..... ( ) ( )

Has your child had any pins, plates, or screws in any bones? ..... ( ) ( )

Circle any of the following which apply to your child:

- |                            |                        |                        |
|----------------------------|------------------------|------------------------|
| Asthma/Breathing Problems  | Heart Murmur           | Liver/Kidney Disease   |
| Blood Disorders            | Heart Problems/Surgery | Rheumatic Fever        |
| Cancer/Tumors              | Hepatitis              | Latex Allergy          |
| Diabetes                   | Herpes/Fever Blisters  | Chemotherapy/Radiation |
| Ear/Nose/Throat Disorder   | HIV (AIDS)             | Handicaps/Disabilities |
| Epilepsy/Seizures/Fainting | High Blood Pressure    |                        |
|                            | Low Blood Pressure     |                        |

Has your child had any other serious illnesses? ..... ( ) ( )

Please list \_\_\_\_\_

Who is your Child's physician? \_\_\_\_\_ Phone Number \_\_\_\_\_

What relationship are you to this child? \_\_\_\_\_

To the best of my knowledge the information I have given is correct. I understand that it is my responsibility to inform this office of any changes. I understand that payment is due at the time of services rendered unless prior arrangements have been made, and I am responsible for payment of any deductibles or co-payments my insurance company does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_