Lakeside Dental
COMMITMENT TO CARE

PATIENT INFORMATION

Today's Date: ____/____/____
CHILD'S NAME: ____ **Preferred Name**: ____________
FIRST MI LAST
(If you are completing this form for another person): Your Name: ___________________________ Relation: ____________

DATE OF BIRTH: _____________ **AGE:** ____ **SEX:** M F **SOCIAL SECURITY #:** ____________________

CHILD'S ADDRESS: ____
Mailing and Street Address city/state zip

MOTHER'S ADDRESS: ____
Mailing and Street Address city/state zip
Phone (home):________________ **Phone (work):**________________ **Phone (cell):** ________________
Email: ____

FATHER'S ADDRESS: ____
Mailing and Street Address city/state zip
Phone (home):________________ **Phone (work):**________________ **Phone (cell):** ________________
Email: ____

PREFERED COMMUNICATION FOR APPOINTMENT REMINDERS:
EMAIL **(Mother's or Father's)** **TEXT** **(Mother's or Father's)** **PHONE** **(Mother's H W C or Father's H W C)**

Mother's Employer/School: ____________________ Occupation: ____________________
Father's Employer/School: ____________________ Occupation: ____________________

DENTAL INSURANCE: YES NO
Subscriber Name:________________________SS#__________________D.O.B.__________Relation:__________

RESPONSIBLE PARTY (Person responsible for account if different than above)
Name: ____________________ Relationship: ____________ Ph (home):____________ Ph (work):____________
Address: ____
Street City/State Zip

EMERGENCY CONTACT
Whom should we contact? _________________________ Relation: ________________ Phone #: ______________

Were you referred to our office? By whom: ____

Please turn off cell phones. Thank you.

MEDICAL INFORMATION

Child's Physician: _______________________________________ Telephone: ________________
Is your child taking any medications? (prescription or over-the-counter)..Yes No
If yes, please list ____

Have you ever been told your child needs antibiotics or premeds before treatment?..........................Yes No

Does your child have any allergic (or adverse) reaction to any medication or other substance?........ Yes No
If yes, please describe ____
____

Are your child's immunizations current?..Yes No

List any Hospitalizations, Surgeries, Serious Illnesses When?
____ ____________________
____ ____________________

Form continues on back

MEDICAL INFORMATION CONTINUED

Indicate which of the conditions your child has now or ever has had:

□AIDS/HIV positive	□Diabetes	□Lung problem
□Allergies or Hives	□Epilepsy	□Measles/Mumps
□Asthma	□Handicaps/Disabilities	□Mononucleosis
□Behavioral/Learning problem	□Hearing problem	□Nervous disorder
□Bleeding disorder	□Heart condition	□Psychiatric/Psychological
□Brain Injury	□Hepatitis ___________	□Rheumatic/Scarlet fever
□Cancer	□Hyperactive/ADD	□Sickle Cell Anemia
□Cerebral palsy	□Kidney/Liver problems	□Stomach problem
□Chicken pox	□Latex sensitivity	□Tonsillitis
□Cleft Lip/Palate	□Leukemia/Anemia	□Tuberculosis
□Congenital heart disease		

DENTAL INFORMATION

What is the reason for your visit today? ____

Your Child's Previous Dentist: ____

Date of your child's last dental visit: ________________________

When does your child brush? ______________________________________ Do you assist? Yes No

Does your child take Fluoride supplements? Yes No

Does your child have any dental problems now? Yes No If yes, please describe: ______________________
____

Are any of your child's teeth sensitive to:
Hot or Cold? Yes No Sweets? Yes No Biting or Chewing? Yes No

Has your child had difficulty with previous dental visits? Yes No If yes, please describe: __________________
____

How do you think your child will handle today's visit? ______________________________________

Does your child have any pain or tenderness in the jaw joint, ear, side of face? Yes No
Has your child complained about dental problems? Yes No
Do your child's gums bleed or hurt? Yes No
Has your child ever worn orthodontic appliances? Yes No

Does your child engage in:

Sucking thumb or fingers?	Yes No	Chewing or biting fingernails?	Yes No
Biting or sucking lips or cheeks?	Yes No	Chewing hard objects (e.g. pencils)?	Yes No
Grinding teeth?	Yes No	Clenching jaw?	Yes No
Mouth breathing?	Yes No	Nursing bottle or pacifier habits?	Yes No

Do you have any special concerns about your child's dental health? Yes No If yes, please describe: __________
____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will inform the office of any change in my child's health or medication.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Parent/Guardian: ______________________________________ **Date:** ______________