Patient Information Sheet

Welcome to our office and thank you for trusting us with your child's dental care.
Please take a moment to tell us a little bit about your child.

Patient Name: _____ D.O.B._____ Age:_____

Address: _____

Telephone: Home_____ Mom's Cell_____ Dad's Cell_____

Parent's email_____

Whom may we thank for referring you to our office?_____

Guardian Information:

Guardian (1) Name_____ D.O.B._____

Address: (if different from above)_____

Relationship to child_____ Do both parents have custodial rights?_____

Guardian (2) Name_____ D.O.B._____

Address:(if different from above)_____

Relationship to child_____

Insurance Information:

Policy Holder Name:_____ DOB_____

Insurance Carrier_____ Subscriber #_____

Group # _____ Phone number_____

Claims Address:_____

I authorize Dr. Walter Glass to perform diagnostic procedures and treatment as indicated for my child's proper dental care. I certify that all of the information on this form is correct to the best of my knowledge.

Guardian Signature_____ date_____

CHILD'S MEDICAL HISTORY

Physician's Name:_____Phone #_____

1. Does your child have a specific medical condition you would like to discuss?
   _____
2. Is your child under a physician's care or been hospitalized recently?
   _____
3. Is your child taking any medications? _____
4. Has your child ever had a heart problem, heart murmur or rheumatic fever? _____
5. Has your child ever had excessive bleeding after a tooth extraction or cut? _____
6. Does your child ever feel faint or dizzy or have seizures? _____
7. Is your child allergic to any medications, anesthetics, latex or metals?
   _____
8. Is your child up to date on their vaccinations? _____

CHILD'S DENTAL HISTORY

1. What is the reason for your child's visit? _____
2. Is this your child's first visit to a dentist? _____
3. Do you brush your child's teeth? _____
4. Does your child brush his/her own teeth?_____
5. Does your child have a history of thumb/finger sucking? _____
6. Does your child eat candy or other sweets or drink soda? _____
7. Has your child ever had an injury to his/her teeth, chin or jaw? _____
8. Is your child afraid to visit the dentist? _____
9. Has anyone in your family had orthodontic treatment? _____
10. Would you like to discuss anything else with us about your child's visit?
    _____

Please answer the following questions if your child has been seen by another dentist.

1. What treatment was done for your child? _____
2. When was their last visit? _____
3. What best describes your child's behavior in the previous dental office?
   Circle one:

Cooperative fearful, but cooperative extremely fearful, unable to cooperate