Arlington Center FOR DENTISTRY

TODAY'S DATE: _____

MINOR AND PEDIATRIC PATIENT INFORMATION

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

NAME: _____ **GENDER:** ☐ MALE ☐ FEMALE
FIRST MIDDLE INITIAL LAST

ADDRESS: _____
NUMBER AND STREET APT. NO.

_____
CITY STATE ZIP CODE

HOME PHONE: _____ **MOBILE PHONE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

SCHOOL: _____ **GRADE:** _____

PARENT / GUARDIAN INFORMATION

MOTHER / GUARDIAN'S NAME: _____
FIRST LAST

ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:** _____ **MOBILE PHONE:** _____

FATHER / GUARDIAN'S NAME: _____
FIRST LAST

ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:** _____ **MOBILE PHONE:** _____

WHO HAS LEGAL CUSTODY OF THE PATIENT? ☐ **MOTHER** ☐ **FATHER** ☐ **JOINT**

WHO IS FINANCIALLY RESPONSIBLE FOR ACCOUNT? _____ _____ _____
NAME SSN DOB

INSURANCE INFORMATION

PRIMARY DENTAL CARRIER

INSURANCE CO. _____ SUBSCRIBER NAME: _____
SSN / ID NO: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____
INSURANCE CO. PHONE NO: _____ EMPLOYER: _____

SECONDARY DENTAL CARRIER

INSURANCE CO. _____ SUBSCRIBER NAME: _____
SSN / ID NO: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____
INSURANCE CO. PHONE NO: _____ EMPLOYER: _____

MEDICAL CARRIER

INSURANCE CO. _____ SUBSCRIBER NAME: _____
SSN / ID NO: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____
INSURANCE CO. PHONE NO: _____ EMPLOYER: _____

Medical History and Information

Has your child been treated for any of the following conditions?

Y	N		Y	N	
☐	☐	ADD	☐	☐	Hepatitis A B C (Please Specify)
☐	☐	Allergies (Seasonal)	☐	☐	Hormone Deficiency
☐	☐	Anemia	☐	☐	High Blood Pressure
☐	☐	Angina	☐	☐	High Cholesterol
☐	☐	Arthritis	☐	☐	Immunosuppresion
☐	☐	Artificial Joint(s)	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Blood Transfusion	☐	☐	Low Blood Pressure
☐	☐	Blood Disorder	☐	☐	Lung Disease
☐	☐	Cancer	☐	☐	Measles / Chicken Pox
☐	☐	Diabetes	☐	☐	Osteoporosis
☐	☐	Drug / Alcohol Abuse	☐	☐	Psychiatric Problems
☐	☐	Emphysema	☐	☐	Rheumatic Fever
☐	☐	Epilepsy / Fainting	☐	☐	Seizures
☐	☐	Fever Blister	☐	☐	STD / Venereal Disease
☐	☐	Headaches / Migraines	☐	☐	Sinus Problems
☐	☐	Gastrointestinal Problems	☐	☐	Speech / Hearing Impairment
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	HIV AIDS	☐	☐	Thyroid Problems
☐	☐	Heart Murmur	☐	☐	Tuberculosis
☐	☐	Heart Disease	Other: _____		

Does your child have allergies?

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Iodine
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Tetrcycline

Other: _____

☐ ☐ Does your child use tobacco products?

For Pedo Patients

☐ ☐ Does your child suck on a pacifier?
☐ ☐ Does your child suck on finger(s) or thumb?
☐ ☐ Was or is your child breast fed?
Until what age? _____
☐ ☐ Was or is your child bottle fed?
Until what age? _____

Please list all medications your child is currently taking: _____

_____

Dental History

Y	N	
☐	☐	Has your child been to the dentist before?

Dentist's name: _____ Date of last visit: _____

☐ ☐ Has your child had any uncomfortable experiences from previous dental care?

If yes, please explain: _____

☐ ☐ Does your child have pain when chewing, yawning or opening wide?
☐ ☐ Is your home water fluoridated?
☐ ☐ Does your child use fluoride toothpaste?
☐ ☐ Do you give your child any other form of fluoride?

If yes, please explain: _____

Consent for Dental Treatment

I authorize the Arlington Center for Dentistry dental team to perform dental services that my child may need and for which I have consented to during diagnosis and treatment, including the use of local anesthesia and other medication. I certify that the medical information provided on this page is current and accurate to the best of my knowledge.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE