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PATIENT INFORMATION

Name _____ Nickname _____ Sex: Male / Female
 First Middle Last
 D.O.B. ____ / ____ / ____ Age _____ Height _____ Weight _____ lbs. SSN ____ / ____ / ____
 Name of School _____ Grade _____
 Child's Home Address _____ City _____ Zip _____

PARENTS INFORMATION

Mother / Step Name: _____ **Social Security #** _____ - _____ - _____ **DL #** _____
Address _____ **City** _____ **Zip** _____
Home Phone # (____) _____ - _____ **Cell Phone #**(____) _____ - _____ **E-Mail** _____
Occupation _____ **Work Phone#** (____) _____ - _____ **Marital Status** Married / Divorced / Widowed / Single
Father / Step Name: _____ **Social Security #** _____ - _____ - _____ **DL #** _____
Address _____ **City** _____ **Zip** _____
Home Phone # (____) _____ - _____ **Cell Phone #**(____) _____ - _____ **E-Mail** _____
Occupation _____ **Work Phone#** (____) _____ - _____ **Marital Status** Married / Divorced / Widowed / Single

MEDICAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

- Describe your child's overall physical health: _____ Excellent / Good / Fair / Poor
1. Is your child currently under the care of a physician? _____ Y / N
If so, please describe _____
 2. Has your child had any serious illness or injury? _____ Y / N
If so, please describe (include age) _____
 3. Have your child's tonsils or adenoids been removed? _____ Y / N
 4. Is your child current on all vaccinations? _____ Y / N
 5. Has your child ever had any of the following:

Abnormal Bleeding	Y / N	Congenital Birth Defect	Y / N	Heart Murmur	Y / N	Rheumatic Fever	Y / N
AIDS/HIV	Y / N	Congenital Heart Defect	Y / N	Hemophilia	Y / N	Scarlet Fever	Y / N
Allergies	Y / N	Diabetes	Y / N	Hepatitis	Y / N	Seizures	Y / N
Anemia	Y / N	Endocrine Disorders	Y / N	Hives	Y / N	Sickle Cell Anemia	Y / N
Asthma	Y / N	Epilepsy	Y / N	Kidney Problems	Y / N	Sinus Problems	Y / N
Bleeding Disorders	Y / N	Frequent Infections	Y / N	Liver / GI Problems	Y / N	Shortness of Breath	Y / N
Blood Pressure	Y / N	Hearing Impaired	Y / N	Lupus	Y / N	Significant Injuries	Y / N
Blood Transfusions	Y / N	Behavioral Disabilities	Y / N	Measles	Y / N	Tonsillitis	Y / N
Breathing Problems	Y / N	Learning Disabilities	Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N
Bone Disorders	Y / N	Mental Disabilities	Y / N	Mononucleosis	Y / N	Thyroid Problems	Y / N
Cancer/Tumors	Y / N	Physical Disabilities	Y / N	Recurrent Headaches	Y / N	Vision Problems	Y / N
Chicken Pox	Y / N	Growth Problems	Y / N	Heart Problems	Y / N		

Does your child have any disease, condition or problem not listed above? _____

Name of child's pediatrician _____ City _____ Phone # (____) _____ - _____

Please list **ALL medications** your child is currently taking _____

Please list **ALL allergies** your child has, including to medication _____

DENTAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

1. Who may we thank for referring you? _____
2. Is this your child's first dental visit? Y/N Previous Dentist _____
Date of Last Dental Exam: ____/____/____ N/A Date of Last Cleaning: ____/____/____
3. What is your reason for bringing your child to the dentist today? _____
4. Has your child experienced any problems with previous dental work? Y / N
If so, please explain _____
5. Is your child nervous or frightened about dental visits? Yes / Somewhat / No / This is our 1st Visit
6. Have there been any injuries to your child's teeth, jaw or chin? Y / N
If so, please explain _____
7. Does your child take fluoride supplements or drink **fluoridated water**? Y / N
8. Has your child ever been seen by an orthodontist? Y / N
If so, who _____ When _____ Where _____
9. Does your child brush his/her teeth daily? Y / N Do they require parental help? Y/N
10. Does your child floss his/her teeth daily? Y / N Do they require parental help? Y/N
11. Does your child have any of the following:

Sleep Apnea	Y / N	Clenching/Grinding	Y / N	Speech Problems	Y / N
Thumb/Finger/Lip Sucking	Y / N	Chewing on Objects	Y / N	Mouth-breathing	Y / N
Nursing Bottle Habits	Y / N	Tongue Thrust	Y / N	TMJ/TMD Pain	Y / N
Pacifier Sucking Habits	Y / N	Snoring	Y / N	Nail Biting/Lip Sucking	Y / N

INSURANCE INFORMATION

Name of Primary Insurance Company _____ Insurance Co. Phone # (____) ____ - ____
Insurance Co. Address _____ City _____ State ____ Zip _____
Insured's Name _____ Group # _____
Relationship _____ D.O.B. ____ / ____ / ____ SSN ____ / ____ / ____
Insured's Address _____ City _____ Zip _____
Insured's Employer _____ Occupation _____
Employment Address _____ City _____ Zip _____ Phone # (____) ____ - ____

Name of Secondary Insurance Company _____ Insurance Co. Phone # (____) ____ - ____
Insurance Co. Address _____ City _____ State ____ Zip _____
Insured's Name _____ Group # _____
Relationship _____ D.O.B. ____ / ____ / ____ SSN ____ / ____ / ____
Insured's Address _____ City _____ Zip _____
Insured's Employer _____ Occupation _____
Employment Address _____ City _____ Zip _____ Phone # (____) ____ - ____

Cancellation Policy: We make every effort to accommodate the busy schedules of our patients and their families. If you are unable to attend your appointment for any reason, we require that you notify our office **AT LEAST 24 HOURS** in advance. If you do not notify us 24 hours in advance, you will be charged a \$50 fee. (Initials) _____

To the best of my knowledge the information I have provided on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Michael A. Shannon, D.D.S., M.S., Inc. Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I have received a copy of this office's Notice of Privacy Practices (HIPAA). I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities, and healthcare operations

Responsible Party Signature _____ Date _____