

About Your Child

Date: ____/____/____

Last Name:		First:	M.I.
Nickname:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate: / /	Age:	SS#	
Special interests, sports or hobbies:			
Home Address:			City:
State:	Zip:	Home #: () -	
Referred By:			

ABOUT YOU

Last Name:		First:	M.I.	<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> DR.
Birthdate: / /		SS#		
Relationship to child:				
Home Address (If different than Child's):			City:	
State:	Zip:	Home #: () -	Cell #: () -	
Occupation:				
Employer:		Work # () -	Ext.	

INSURANCE INFORMATION

PRIMARY COVERAGE		Dental Coverage: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Insurance Company:			Ph #: () -	
Insurance Address:		City:	State	Zip
Group # (Plan, Local or Policy #):		Insured's ID #		
Insured's Employer:		Insured's Name:		
Relation:		Insured's Birthday: ____/____/____		

SECONDARY COVERAGE

SECONDARY COVERAGE		Dental Coverage: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Insurance Company:			Ph #: () -	
Insurance Address:		City:	State	Zip
Group # (Plan, Local or Policy #):		Insured's ID #		
Insured's Employer:		Insured's Name:		
Relation:		Insured's Birthday: ____/____/____		

In case of an emergency, whom should we contact?	
Name:	Relationship:
Phone #: () -	Phone 2 #: () -

DENTAL / MEDICAL HISTORY (Continued on page 2)

Has your child been to the dentist before? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, the approximate date of the last visit:
Are there any dental problems that you are aware of at present? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please explain:	
Does your child brush his / her teeth daily? <input type="checkbox"/> YES <input type="checkbox"/> NO	Please rate your child's oral health: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor



Gentle Family Dentistry of Naperville

10 E. Benton Ave., Naperville, IL 60540

Phone: (630) 355-0100 | Fax: (630) 355-0572 | Email: info@naperdent.com

DENTAL / MEDICAL HISTORY (Continued)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Does your child have a personal physician?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date of last visit:
Physician's Name:			Ph #: () -
Is your child under a physician's care now?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Is your child taking any medications, pills or drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Has your child ever been hospitalized or had a major operation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Has your child ever had a serious head or neck injury?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Has your child taken Fosamax, or any other bisphosphonate	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Has your child taken Phen-Fen or Redux?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Is your child on a special diet?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Does your child smoke or use tobacco?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Does your child use controlled substances?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Is your child pregnant or trying to get pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Does your child taking oral contraceptives?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Is your child nursing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, please explain:
Is your child allergic to any of the following?	Aspirin	Penicillin	Codeine Local Anesthetics Metal Latex Acrylic
Other? If yes, please explain:			

DOES YOUR CHILD HAVE, OR HAS YOUR CHILD HAD, ANY OF THE FOLLOWING?:

AIDS HIV Positive	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Excessive Thirst	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Lung Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Alzheimers	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Fainting Spells / Dizziness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anaphylaxis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Frequent Cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pain in the Jaw Joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Frequent Diarrhea	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Parathyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Angina	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Frequent Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis/Gout	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Genital Herpes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Radiation Treatments	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Recent Weight Loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial Joint	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hay Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Renal Dialysis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Attack/Failure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatism	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood Tranfusion	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Pace Maker	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Breathing Problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Trouble/Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Shingles	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bruise Easily	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sickle Cell Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis A	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis B or C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Spinal Bifida	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stomach/Intestinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cold Sores/Fever Blisters	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Congenital Heart Disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hives or Rash	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Swelling of Limbs	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Convulsion	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hypoglycemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cortisone Medication	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Irregular Heartbeat	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tonsillitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Drug Addiction	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Leukemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tumors or Growths	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Easily Winded	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy or Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Excessive Bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Yellow Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Have your child ever had any serious illness not listed above? YES NO If yes, please explain: _____

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE ____/____/____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

Signature _____ Date _____

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I hereby acknowledge that a copy of this office'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.

Signature of patient: (Parent or Guardian if minor)X _____ Date _____