

Please *print* in ink.

Child's Information				
Last Name	First	Middle		
Preferred Name	Date of Birth	Age	SSN	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Does patient attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, where?	Grade	
Child's Physician		Phone #		
Address of Physician				
Parent Information				
Mother's Full Name		Date of Birth	SSN	
Address		City	State	ZIP
Home #	Cell #	Work #		
Employer				
If the above information is not for the mother, what is relationship to child?				
Father's Full Name		Date of Birth	SSN	
Address		City	State	ZIP
Home #	Cell #	Work #		
Employer				
If the above information is not for the father, what is relationship to child?				
Who does the child live with? <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:				
How did you hear about us?				
Insurance Information				
Insurance Carrier				
Insurance Carrier Phone #		Policy #		
Policy Owner's Name		Relationship		
Policy Owner's Employer				
Emergency Contact Information				
Name (other than spouse):		Relationship to Child		
Address		City	State	ZIP
Home #	Cell #	Work #		

I understand that I am responsible for payment at the time services are rendered, regardless of insurance coverage. Wren Pediatric Dentistry is not obligated to file your insurance for you; however, we offer this service because we know how burdensome this can be for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. If your insurance company has not paid your bill after 30 days, you will be responsible for payment. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim.

Signature

Date

For Office Use Only: S E H

Health History	
<i>Select any of the following that pertain to your child.</i>	
HEART	Heart murmur, mitral valve prolapse, rheumatic fever, congenital heart defect, low/high blood pressure, heart surgery, other heart problem (if so, please list)
KIDNEY	Bladder, urinary problems
LIVER/GI	Stomach/intestinal ulcers, gastritis, colitis, diarrhea, jaundice, hepatitis, liver disease, reflux (GERD)
ENDOCRINE SYSTEM	Diabetes, thyroid disease
HEMATOLOGIC	Blood transfusion, anemia, hemophilia, leukemia, sickle cell disease, prolonged bleeding
LUNG/BREATHING	Hay fever, sinus trouble, allergies or hives, asthma, chronic cough, emphysema, TB or tuberculosis
NEUROLOGICAL	Nervous disorder, mental disorder, cerebral palsy, seizure disorder/epilepsy, fainting, retardation, brain injury, developmental delay, headaches, speech disorder
HEARING/EYE	Vision problems, glaucoma, eye pain, earaches, hearing loss
DERMAL/ MUSCULOSKELETAL	Rash, allergy to latex, arthritis, fever blisters, ulcers
Does the patient have any disease, condition or other health problem not listed above? If so, please list. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient currently taking any medications? If so, please list. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is he/she up to date with immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has he/she been hospitalized since birth? If yes, why? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has he/she ever had surgery? If yes, why? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have any allergy to medications or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is he/she presently receiving medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, for what?	
When was child's last physical exam?	
Describe your child's personality.	

Dental History	
Date of patient's last dental visit	Name of Dentist
Were x-rays taken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient had any unhappy dental experiences?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.	
Does the patient have a toothache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
At what age did patient discontinue the bottle or nursing? ____ years ____ months	
Does patient have any mouth habits (thumb/finger sucking, pacifier, grinding, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.	
Does patient have any TMJ pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient had any injuries to the mouth, teeth or head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.	
Does patient brush daily? (If yes, how many times? _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient use floss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What type of water is used for brushing? <input type="checkbox"/> City water fluoride <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water	
Does an adult assist the patient with the above? (If yes, who? _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If there is additional information that you feel might be of value to us, please comment.	

Signature	Date
Relationship to patient	