



Pediatric and Adolescent Dentistry

Ronald A. Curren, D.D.S.

Tell Us About Your Child

Today's Date _____ Child's Home Phone # _____ Soc. Security # _____

Child's Name _____ Child's Birthdate ____/____/____ Child's Age _____
Last First

Nickname _____ Male Female School _____ Grade _____

Child's Home Address _____
Street City State Zip

Who may we thank for referring you? _____

Parent's Information

Parent's Marital Status: Married Divorced Separated Widowed Remarried Single

Mother Birthdate: ____/____/____ Home Phone (____) _____ Work Phone (____) _____

Name: _____ Social Security # _____ Driver's Lic. _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Father Birthdate: ____/____/____ Home Phone (____) _____ Work Phone (____) _____

Name: _____ Social Security # _____ Driver's Lic. _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Insurance Information

Primary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No No Medical? Yes No

Insurance Co. _____ Phone # (____) _____ Group # (Plan, Local or Policy#) _____

Insurance Company Address: _____
Street or P.O. Box City State Zip

Insured's Name: _____ Relationship to Child: _____

Insured's Birthdate: ____/____/____ Social Security # _____ Insured's Employer: _____

Secondary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No No Medical? Yes No

Insurance Co. _____ Phone # (____) _____ Group # (Plan, Local or Policy#) _____

Insurance Company Address: _____
Street or P.O. Box City State Zip

Insured's Name: _____ Relationship to Child: _____

Insured's Birthdate: ____/____/____ Social Security # _____ Insured's Employer: _____

Dental History

Is the child currently in pain? Yes No What is the primary reason for today's visit? _____

Has the child experience problems with previous dental treatment? Yes No

Does the child brush his / her teeth daily? Yes No Who does the brushing? Child Mother Father

Does the child floss daily? Yes No

Does child drink... tap water bottled water (_____) well water? Is the water fluoridated? Yes No

Does the child take a fluoride supplement? Yes No If yes, dose _____

What brand of toothpaste does the child use? _____

Previous Dentists Name: _____ Date of Last Visit?: _____

Why did you leave the previous dentist? _____

What did you like most about that dentist? _____ Least: _____

Does the child have any of the following habits?:

Y N Lip Sucking / Biting	Y N Clenching / Grinding	Y N Tongue / Cheek Biting	Y N Mouth Breather
Y N Nail Biting	Y N Thumb / Finger Sucking	Y N Pacifier	Y N Speech Problem
Y N Chewing on Objects	Y N Nursing Bottle Habits	Y N Tongue Thrust	Y N Breast Fed

Notes: _____

Medical History

Child's Physician _____ Phone # _____ Date of last visit _____

Address _____
Street City State Zip

Is the child currently under the care of a physician? Yes No Please explain _____

Please describe the child's current physical health: Good Fair Poor Are immunizations current? _____

Please list all drugs your child is currently taking: _____

Please list all drugs and / or things that cause your child to have an allergic reaction _____

Anything you would like to discuss in private? Yes No

Has the child had any / experienced the following:

Y N Abnormal Bleeding	Y N Chicken Pox	Y N Hepatitis	Y N Mononucleosis
Y N AIDS / HIV+	Y N Congenital Heart Defect	Y N High Blood Pressure	Y N Rheumatic Fever
Y N Allergies	Y N Convulsions	Y N Hives	Y N Scarlet Fever
Y N Anemia	Y N Diabetes	Y N Kidney Problems	Y N Sickle Cell
Y N Any Hospital Stays	Y N Epilepsy	Y N Liver Problems	Y N Skin Rash
Y N Any Operations	Y N Handicaps / Disabilities	Y N Low Blood Pressure	Y N Tonsillitis
Y N Asthma	Y N Hearing Problems	Y N Lupus	Y N Tuberculosis
Y N Blood Transfusions	Y N Heart Murmur	Y N Measles	
Y N Cancer	Y N Hemophilia	Y N Mitral Valve Prolapse	

Please discuss any serious medical problems the child experience(s)(ed): _____

Authorization

I affirm that the above information I have given is correct and to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the doctor all insurance benefits. I understand that I am responsible for payment of services rendered and any deductible and co-pay that my insurance does not cover. All accounts referred to an outside collection agency will be charged an additional 30% collection fee or attorney's fee payable by parent or guardian.

Signature _____ Date _____