



**Pediatric and Adolescent Dentistry**  
**Ronald A. Curren, D.D.S.**  
**Lina T. Cao, 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 \_\_\_\_\_