



ATLANTIC
DENTAL
WELLNESS

www.HolisticSmiles.com

YOUR CHILD

Child's Name: _____ Sex: M F Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Nickname: _____ Social Security#: _____ - _____ - _____ Birthdate: ____/____/____

School: _____ Grade: _____

Do you already have an appointment? Yes Date: _____ Time: _____ AM PM ; No Please Call To

Arrange

PARENT OR GUARDIAN INFORMATION (MOTHER OR GUARDIAN)

Name: _____ Relationship: _____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security # _____ - _____ - _____ Birthdate: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone _____

PARENT OR GUARDIAN INFORMATION (FATHER OR GUARDIAN)

Name: _____ Relationship: _____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security # _____ - _____ - _____ Birthdate: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone _____

PRIMARY DENTAL INSURANCE

Insured's Name: _____ Relationship: _____

Social Security # _____ - _____ - _____ Birthdate: _____

Employer: _____

Insurance Company _____ Group# _____ ID# _____

Ins. Co. Address _____ City: _____ State: _____ Zip: _____

Patient Health History

Patient Name _____ Birth Date ____ / ____ / ____

Child's Physician _____ Phone # _____

Who May We Thank for Referring You? _____

Purpose of Today's Visit _____

Date of Last dental Visit ____ / ____ / ____ Previous Dentist _____

1. Does your child have any specific medical conditions- tuberculosis, cancer, cerebral palsy, etc? If so, please specify _____ YES NO
2. Does your child have any special limitations either mental or physical? YES NO
If so, please specify _____
3. Has your child ever had an operation? YES NO
If so, please specify _____
4. Have you ever been told by a physician that your child had/has a heart murmur, Rheumatic fever, or a shunt? YES NO
At what age? _____ was a cardiogram ever done? _____ is antibiotic needed for dental treatment? _____
5. Does your child have asthma or breathing problems? YES NO
6. Does your child have a history of seizures? YES NO
7. Has your child ever tested positive for Hepatitis or HIV? YES NO
If so, please specify _____
8. Does your child have any allergies to
Antibiotics YES NO
Analgesics (aspirin, codeine) YES NO
Latex YES NO
Pollen, Grass, Dust YES NO
9. Is your child now taking any medicine? If so please specify _____ YES NO
10. Does your child have any learning disabilities, ADD or ADHD? YES NO
If so, please specify _____
11. Has your child has a history of thumb sucking, finger sucking, lip sucking, pacifier use or nail biting? If so, please specify _____ YES NO
12. Has your child ever has any unfavorable experience in a medical or dental office? YES NO
13. Does your child participate in any sports? YES NO
If so, please specify _____
14. Has your child ever has any injuries to the teeth, mouth, head or neck? YES NO
If so, please specify _____
15. Has your child had a toothache lately? _____ If yes, was it after eating? _____
16. Are there any other conditions or concerns not listed here? YES NO
If so, please specify _____

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 child's health.

Signature of Parent or Guardian Date ____ / ____ / ____

Signature of Doctor Date ____ / ____ / ____