CORNERSTONE CHILDREN'S DENTISTRY, P.A.

I. SOCIAL HISTORY

Patient's Full Name _____ **Preferred Name** _____ **Age** _____

Sex _____ **Race** _____ **Date of Birth** _____ **Place of Birth** _____

Patient's Address _____ **Parent's Email** _____

School _____ **Child's Social Security #** _____

Name and type of child's pet _____ **Favorite interest / hobby** _____

How do you expect your child to react to his/her visit today? Excellent Good Fair Poor Not sure

Child lives with: Both parents Mother Stepmother Father Stepfather Grandparent Other _____

Father's Full Name _____ **Home Phone** _____ **Work Phone** _____

Father's Address _____ **Mobile Phone** _____

Mother's Full Name _____ **Home Phone** _____ **Work Phone** _____

Mother's Address _____ **Mobile Phone** _____

Emergency Contact Name (if parent unavailable) _____ **Emergency Contact Phone** _____

Other children in the family (Names and ages) _____

How did you hear about our office? Doctor _____ **Patient** _____ **Other** _____

Reason for bringing child to the dentist _____

II. MEDICAL HISTORY

Child's Physician _____ **Year of last physical exam** _____ **Physician's Phone** _____

Physician's Address _____

Yes No Were there any problems during pregnancy or birth of your child? _____

Yes No Are your child's immunizations up to date? If not, why? _____

Yes No Is your child allergic to any medicines or foods? If yes, what? _____

Yes No Is your child taking any medicines? If yes, what? _____

_____

Yes No Has your child been hospitalized? If yes, explain. _____

_____

Yes No Has your child had any surgeries? If yes, explain. _____

_____

Yes No Has your child received medical treatment within the last 6 months? If yes, explain. _____

_____

Yes No Does your child have any hearing, sight, speech, or learning problems? If yes, explain. _____

_____

Please check any that pertain to your child (past or present):

Heart Condition / Heart Murmur	**Allergies**	**Bleeding Disorder**	**Tuberculosis**
Asthma	**Seizure Disorder**	**ADHD**	**Cerebral Palsy**
Blood Transfusion	**Liver Problems**	**Kidney Problems**	**Diabetes**
Sickle Cell Anemia	**Mental / Emotional Disorder**	**Rheumatic Fever**	**Hepatitis**
Nervous System Disorder	**HIV / AIDS**	**Other** _____	

III. DENTAL HISTORY

Yes No Is this your child's first dental visit? If no, name of previous dentist _____

Yes No Are there any hereditary dental problems in the family (missing, extra teeth, etc.)? _____

Yes No Has your child or any family member experienced any unfavorable reaction to dental treatment? _____

Yes No Has your child suffered injuries to the head, mouth, or teeth? Explain _____

Yes No Does your child have a thumb, finger , or pacifier habit? _____

Yes No Does your child take fluoride supplements? Is drinking water: Public / City Water Private Well Bottled Water

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I attest that the above information is true to the best of my knowledge. I also consent to the performance of a diagnostic exam, radiographs, dental cleaning, and fluoride treatment upon my child as deemed necessary and appropriate by the dentist.

Signature of Parent / Legal Guardian _____ **Date** _____