Welcome to Clear Lake Dental Center

Chart #______

About Your Child

Patient Name Last______________________First____________________MI_______ Preferred name ______________date____________

Gender (M/F) Birth date: __/__/____ Parent's Home Phone #:_________________Cell#________________

Parent's address: Street____Apartment#_________

City____State_______________Zip Code______________

Child's Family

WHO IS ACCOMPANYING THIS CHILD TODAY ? ______________________ RELATIONSHIP TO CHILD__________________CHECK IF ADDRESS IS THE SAME AS PATIENT _______

Mother's/Guardian's Name ______________________________________Date of Birth___/___/_____

Address: Street____Apartment#__________________

City____State________________Zip Code___________

Phone #'s: Home___________________________Work__________________________Ext.__________ Cell__________________________________

Email Address: ____Driver's License #:__________________

Social Security#:__________________________Do you have legal custody of this patient (Y / N)

Employer Name: ____Occupation:________________________

Father's/Guardian's Name ______________________________________Date of Birth___/___/_____

Address: Street____Apartment#__________________

City____State________________Zip Code___________

Phone #'s: Home___________________________Work__________________________Ext.__________ Cell__________________________________

Email Address: ____Driver's License #:__________________

Social Security#:__________________________Do you have legal custody of this patient (Y / N)

Employer Name: ____Occupation:________________________

Primary Dental Insurance Information

Name of Insured: ____Is insured a patient? (Y / N)

Billing Address: Street____Apartment#________

City____State_______________Zip Code____________

Insured's relationship to Patient: Father ______Mother _______Guardian______ Other________________

Insurance Plan Name __________________________ID#_________________________Group#________________

Customer Service Phone #____

Referral Information

Whom may we thank for referring you to our practice? ____

Patients Name____

Dental History

Reason for today's visit____

Date of last dental care_________________________ Date of last dental x-rays____________________

Check (X) if you have had problems with any of the following:

BAD BREATH ___ LOOSE TEETH OR BROKEN FILLINGS ___ SENSITIVITY TO: HOT___ COLD ____ SWEET ____ WHEN BITING____ BLEEDING GUMS_____

PERIODONTAL TREATMENT _____CLICKING OR POPPING JAW____ GRINDING TEETH ____ FOOD COLLECTION BETWEEN TEETH___ SORES OR GROWTHS IN YOUR MOUTH ____ TOBACCO USE _____

Medications

List all medications you are currently taking:

____

____

____

____

Pharmacy name________________________

Allergies

___ASPIRIN __PENICILLIN

__BARBITURATES (sleeping pills) __SULFA

__ LOCAL ANESTHETIC __CODEINE

__LATEX __OTHER________

____

Medical History

Physician's name____ Date of last visit____________

Have you had any serious illness or operation (Y /N) If yes, describe____

(Women) Are you pregnant ___ Nursing __ Taking birth control pills ____ Had Abnormal Pap ___ Abnormal Mammogram____

Circle any of the following you have or have had:

Anemia	Blood Transfusion	Epilepsy or Seizures	Hepatitis A B C	Pacemaker
Arthritis, Rheumatism	Bruise Easy	Fainting or dizzy spells	High Blood Pressure	Psychiatric Disorder
Artificial Heart Valves	Cancer__________	Glaucoma	HIV Positive	Respiratory disease
Joint Replacement_________	Chemotherapy/Radiation	Headaches	HPV Positive	Swelling of feet/ankles
Asthma	Cortisone Treatments	Heart Murmur	HPV Vaccine	Thyroid Disease
Back Problems	Cough, Persistent	Heart problems___________	Kidney Trouble	Tuberculosis
Blood Disease	Diabetes (I / II)	Heart Surgery____________	Liver Disease	Ulcers

I understand the above information and to the best of my knowledge, the preceding answers are true and correct. If there are any changes to my health or medication or any other information I have provided it is my responsibility to inform CLEAR LAKE DENTAL CENTER.

Signature of Patient or Responsible party ____Date_____ /___/________