DR. PURNIMA SWEARINGEN D.D.S.,M.S.D.

Child's Name: _____ Date of Birth: _____
Residence: _____ City: _____ State: _____ Zip: _____
School: _____ Grade: _____
Child's favorite toy: _____ pet: _____ Friend: _____ Hobby: _____
Child's attitude towards dental visit: _____

Father's Name: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Employed By: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Employed By: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Name and ages of other siblings: _____

Emergency contacts

Nearest Relative: _____ Phone: _____
Nearest Friend: _____ Phone: _____

PERSON RESPONSIBLE FOR PAYMENT _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Company _____	_____
Policy Holder: _____	_____
Social Security No: _____	_____
I. D. #: _____	

Whom should we thank for referring you to our practice? _____

THANK YOU FOR CHOOSING OUR OFFICE.

Child's First Name _____ **Last Name** _____ **Date of Exam** _____

Child's Health History

General Health ____ excellent ____ good ____ fair ____ poor

Child's Physician: _____ Phone: _____

Address: _____

Date of last physical exam: _____

Check if your child had or now has any of the following condition(s):

___ A.I.D.S./HIV	___ Bleeding Disorder	___ Cerebral Palsy
___ Kidney disease	___ Anemia	___ Bone Disorder/Fracture
___ Diabetes	___ Asthma	___ Endocrine
___ Rheumatic fever	___ Heart trouble	___ Arthritis
___ Hepatitis	___ Epilepsy/convulsions	___ Broken bones
___ Liver disease	___ Speech impediment	___ A.D.H.D.
___ Tuberculosis	___ Hearing problem	___ Mononucleosis

Other _____

Does child have any allergies? ____ yes ____ no
If Yes, To What?

Does child have any emotional problems? ____ yes ____ no

Is child taking any medications now? ____ yes ____ no
If yes, please describe

Has your child ever used: ___ Drugs ___ Alcohol ___ Tobacco Products

Is your child pregnant? ____ yes ____ no
How long: Months _____ Weeks _____

I VERIFY THE ABOVE INFORMATION

_____

PARENT / GUARDIAN'S SIGNATURE

Child's Dental Information

1. How long since your child's last dental examination?

2. What concerns you most about your child's dental health?

3. Does your child ever have dental pain? If so, when?

4. Did your child ever have a negative dental experience:
   Please explain.

5. Has the child had any injuries to the face: _____
   (Please Check) ____ mouth ____ teeth ____ face
   When? _____ Where _____
   How? _____
   _____

6. Has the child ever sucked a thumb or fingers? Until what age? _____

7. Does the child snore or grind his/her teeth?

8. Is the child a mouth-breather?
   While awake? _____ While asleep? _____

9. Has the child had teeth removed?

10. Has the child had orthodontic treatment?

11. How often does your child brush? ____ times Floss? ___

12. Has child received any flouride ____ pill/vitamins ____ water