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Specialist in Pediatric Dentistry

Patient Information:

Child's Complete Name: _____ Nickname: _____ Sex: _____

Age: _____ Date of Birth: _____ Social Security Number: _____

School: _____ Hobbies: _____

Are parents married, separated or divorced and who does the child live with _____

Name and Age of Siblings: _____

Who may we thank for referring you to our office? _____

Family or Guardian Information:

Step / Father's Complete Name: _____ Date of Birth: _____

Social Security Number: _____ Drivers License: _____

Address: _____ City: _____ Zip _____

Home Ph: _____ Employer: _____ Work Ph: _____

Step / Mother's Complete Name: _____ Date of Birth: _____

Social Security Number : _____ Drivers License: _____

Address: _____ City: _____ Zip _____

Home Ph: _____ Employer: _____ Work Ph: _____

Emergency contact and relationship: _____ Phone: _____

Cellular Phone / Pager: _____

Preferred Contact Phone: _____

Step / Father's Employer: _____ Insurance Carrier: _____

Group #: _____ Phone: _____

Step / Mother's Employer: _____ Insurance Carrier: _____

Group #: _____ Phone: _____

Other Dental Insurance: _____ Group / Policy#: _____

Phone: _____ **Who is responsible for this account:** _____

Medical History:

Child's Physician _____ Phone # _____ Date of last visit: _____

Is your child in good general health? _____

Describe your child's social development ___normal ___advanced ___delayed

Describe your child's temperament: _____

Is your child taking any medications? ___yes ___no

Please list and give doses: _____

Has your child had any reactions or allergies to any medications? ___yes ___no

Please list: _____

Has your child had any hospital stays? ___yes ___no

Please list and give dates: _____

Has your child had any operations? ___yes ___no

Please list and give dates: _____

Has your child had any traumatic injuries? ___yes ___no

Please list and give dates: _____

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Please circle any of the following medical problems your child has experienced:

Asthma	Lung Problems	Heart Disease
Behavior difficulties	Tuberculosis	Blood Dyscrasias
Learning difficulties	Recurrent infections	Transfusions
Food allergies	Kidney Problems	Heart Murmur
Hay fever	Liver Problems	Rheumatic Fever
Seasonal allergies	Hepatitis	Prolonged bleeding
Birth defects	Jaundice	Hemophilia
Cleft palate or lip	Diabetes	Leukemia
Difficulty with speech	Endocrine System Problems	Tumor
Difficulty with hearing	Epilepsy	Malignancy
Eye disorders	Seizures	HIV/AIDS
Ear infections	Recurrent headaches	Mental Retardation
Throat infections	Problems with jaw joints	Disabilities

Other: _____

Dental History:

Has your child been seen in any other dental office? ___yes ___no

Date of last dental exam: _____ Treatment provided: _____

Date of last dental x-rays: _____ Dentist's name : _____ Phone # _____

Has your child experienced any unpleasant medical or dental treatment? ___yes ___no

Explain: _____

Does your child have any cavities that you are aware of? ___yes ___no

Is your child experiencing any dental pain today? ___yes ___no

Has your child had any trauma to the teeth or gums? Explain: _____

Does your child have any habits such as finger sucking or pacifier? ___yes ___no

Does your child brush every day? ___yes ___no

Do you assist in brushing and flossing for your child? ___yes ___no

Is your drinking water fluoridated? ___yes ___no

Is your child using fluoride supplements? ___yes ___no

Is your child feeding by breast or bottle? ___yes ___no

Do you like the way your child's teeth look? ___yes ___no

What would you change? _____

Other: _____

Authorization for Treatment:

I authorize this dental office to perform an examination and x-rays necessary to diagnose my child's dental health. I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

Signature: _____ Date: _____

Relationship to patient: _____