**PATIENT INFORMATION**

PARENT/RESPONSIBLE PARTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST NAME LAST NAME MIDDLE NAME

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: MALE/FEMALE

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: CA

PHONE # (\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_ EMERGENCY # (\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER DATE OF BIRTH:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

FIRST NAME LAST NAME

RELATION TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER INSURANCE ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

-NAME OF YOUR GENERAL DENTIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-NAME OF YOU PRIMARY DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-WHO REFERED YOU TO OUR OFFICE? *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-WHEN WAS YOUR LAST DENTAL VISIT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***HEALTH HISTORY***

**MARK X TO ALL THAT APPLY**

-DO YOU OR YOUR CHILD HAVE SPEECH PROBLEM/THERAPY? YES \_\_ NO \_\_

-DO YOU OR YOUR CHILD GRIND OR CLENCH THERE TEETH? YES \_\_ NO \_\_

-ORAL HABITS (THUMB, FINGER OR LIP -SUCKING /NAIL BITTING)? YES \_\_ NO \_\_

-SNORES DURING SLEEP? YES \_\_ NO \_\_

- HAVE YOU HAD ORTHODONTIC TREATMENT*?* YES \_\_ NO \_\_

-DO YOU SMOKE/OR USE TOBACCO (ANY FORM YES \_\_ NO \_\_

-DO YOU HAVE IMPLANTS? YES \_\_ NO \_\_

-ARE YOU TAKING ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATION? YES \_\_ NO \_\_

-DOES YOUR JAW CRACK? / YES \_\_ NO \_\_

- DO YOU HAVE PAIN IN YOUR JAW? YES \_\_ NO\_\_

-DO YOU NEED PRE-MEDIATION FOR YOUR DENTAL VISITS? YES \_\_ NO \_\_

LIST ANY ALLERIES YOU HAVE INCLUDING METAL OR LATEX? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?**

**MARK X TO ALL THAT APPLY**

-AIDS YES \_\_ NO \_\_ -LOW BLOOD PRESSURE YES \_\_ NO \_\_

-HIV YES \_\_ NO \_\_ -HERPES YES \_\_ NO \_\_

-ANEMIA YES \_\_ NO \_\_ -AUTISM YES \_\_ NO \_\_

- ADHD YES \_\_ NO \_\_ -ASTHMA YES \_\_ NO \_\_

- AUTO IMMUNE DISEASE YES \_\_ NO \_\_ -ARTHRITIS YES \_\_ NO \_\_ -CANCER / CHEMOTHERAPY YES \_\_ NO \_\_ -CONGENITAL HEART DEFECT YES \_\_ NO \_\_ -DIABETES YES \_\_ NO \_\_ -RESPIRATORY DIFFICULTY YES \_\_ NO \_\_ -ULCERS YES \_\_ NO \_\_

**AS THE PATIENT/ LEGAL GUARDIAN I STATE THAT I HAVE THROUOUGLY READ THIS HEALTH WAIVER AND ANSWERED TO THE BEST OF MY KNOWLEDGE.**

**PATIENT/ LEGAL GUARDIAN SIGNATURE:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_