**Welcome To Paxton Family Dental**

**Patient Information**

First Name: M.I.: Last Name: Nickname:

M F DOB: SS#: School: Grade:

Does the patient have any immediate family members that come here? Y N If yes, please name:

Home Address: City: State: Zip:

*Whom may we thank for referring you to us?*

**Primary Parent/Guardian Information**

Mother Father Guardian Last Name: M.I.: First Name:

DOB: SS# Employer:

Mailing Address: City: State: Zip:

Home Phone: Cell: Work: Ext.:

Preferred Contact Phone: Home Cell Work Email:

**Secondary Parent/Guardian Information**

Mother Father Guardian Last Name: M.I.: First Name:

DOB: SS# Employer:

Mailing Address: City: State: Zip:

Home Phone: Cell: Work: Ext.:

Preferred Contact Phone: Home Cell Work Email:

**Primary Dental Insurance**

**If no insurance, complete this section for the person responsible for this account.**

Insureds’ Last Name: M.I. First Name:

Mailing Address: City: State: Zip:

Home Phone: Cell: Other:

Preferred Contact Phone: Home Cell Other Email:

DOB: SS# Drivers Lic.: Relationship to Patient:

Employer: Dental Ins. Co.: Subscriber ID: Group #:

**Secondary Dental Insurance**

Insureds’ Last Name: M.I. First Name:

Mailing Address: City: State: Zip:

Home Phone: Cell: Other:

Preferred Contact Phone: Home Cell Other Email:

DOB: SS# Drivers Lic.: Relationship to Patient:

Employer: Dental Ins. Co.: Subscriber ID: Group #:

**Payment/Authorization**

I understand that payment is due in full at each visit unless otherwise agreed upon in writing. I hereby authorize payment directly to Paxton Family Dental of the group insurance otherwise payable to me. I understand I am responsible for all costs of dental treatment. I hereby authorize Paxton Family Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

**Patient/Responsible Party Signature: Date:**

**Your Child’s Medical History**

**Please check the following for allergies:**

Latex Penicillin/Amoxicillin Erythromycin Tetracycline Aspirin Codeine Iodine

Sulfa Percodan Valium Acrylic Metals Dental Anesthetic Other:

**Please check any of the following symptoms or conditions that you have or have had in the past.**

AIDS/HIV InfectionADHD Allergies Artificial Heart Valves (Date Placed: )

Artificial Joints (Date Placed: ) Asthma Autism Birth Defects Cancer

Cerebral Palsy Chemotherapy Cleft Lip/Palate Congenital Heart Defect Diabetes

Difficulty Breathing Dizziness/Fainting Downs Syndrome Epilepsy Hearing Problems

Heart Murmur Hemophilia Hepatitis A, B or C High Blood Pressure Hypoglycemia

Kidney Disease Leukemia/Anemia Liver Disease Low Blood Pressure Nervousness

Psychiatric Care Radiation Respiratory Problems Rheumatic Fever Scarlet Fever

Seizures Thyroid Disease Tuberculosis

**Please list any heart conditions:**

**Is your child currently under a physician’s care?** Y N If yes what for:

**Please list any medications your child is currently taking:**

**Your Child’s Dental History**

**How many times a day does your child brush?**  **How many times a week does your child floss?**

Is your child’s water fluoridated? Y N

**Does your child do any of the following?** Thumb/Finger suck Tongue thrusting or sucking Mouth breath/snore

**Please check any of the following problems that apply to your child.**

Sensitive tooth, teeth or gums Blisters or sores in/around mouth Red, swollen, or bleeding gums

Discomfort, clicking, popping or locking j aw Loose tooth Bad breath Broken/chipped tooth/teeth

Grinding teeth Ringing in ears Stained teeth

Please list any other dental symptoms your child may be experiencing:

**If known, please list the following dates:**  Last Exam Last X-Rays

**Previous dentist?** Reason for leaving?

**Siblings and Favorite Things**

Please list any siblings your child may have and their age:

Please list any pets your child may have and their name:

What is your child’s favorite color? What is your child’s favorite book or toy?

What is your child’s favorite hobby? What is your child’s favorite movie?

Does your child play any sports?

Parent/Guardian Signature: Date:

Doctors Signature: Date: