IRISH ROAD
DENTAL

Tell Us About Your Child

Today's Date: ____/____/____ Preferred Name:_____

Child's Name: _____
LAST FIRST MI

Birthdate: _____/_____/____ Age:_____ □ Male □ Female

Address:_____

_____
CITY STATE ZIP

Home Phone:_____

Cell Phone:_____

Email:_____

General Information

Who is accompanying child today?

_____

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?

_____

Other siblings/ages: _____

_____

Hobbies:_____

Parents' Information

□ Father □ Stepfather □ Guardian

Marital Status: S M D W Birthdate: _____/_____/_____

Name: _____

Address: (If different than child's)

_____

_____

Home Phone: _____ Cell: _____

Work Phone:_____ SSN:_____

Employer: _____

Email: _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insured's ID #: _____ Group #: _____

Ins. Phone: _____

Driver's License: _____ SS#: _____

□ Mother □ Stepmother □ Guardian

Marital Status: S M D W Birthdate: _____/_____/_____

Name: _____

Address: (If different than child's)

_____

_____

Home Phone: _____ Cell: _____

Work Phone: _____ SSN: _____

Employer: _____

Email: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insured's ID #: _____ Group #: _____

Ins. Phone: _____

Driver's License: _____ SS#: _____

(PLEASE COMPLETE BACK OF FORM)

Dental and Medical History

Has your child been to a dentist before? Y / N Previous General Dentist:_____

Last Dental Visit:_____ What are the main concerns?:_____

Is your child currently in pain? Y / N Please specify: _____ Any pain in the jaw joint? Y / N

Has your child experienced any unfavorable reaction from any previous dental care? Y / N Please specify: _____

Please rate your child's oral health: Good / Fair / Poor Does your child brush his/her teeth daily? Y / N

Does your child require antibiotics before dental procedures? Y / N If yes, please specify reason: _____

Are you currently under a physician's care? Y / N If yes, explain: _____

Family Physician:_____ Phone: _____

Address:_____

Date of last visit to physician: ____ /____ /____ Please rate your child's mental health: Good Fair Poor

Are you taking any medicine at this time? Y / N Please specify: _____

Are you allergic to any medications? Y / N Please specify: _____

Are you allergic to the following medications?

Yes / No Penicillin **Yes / No** Tetracycline **Yes / No** Erythromycin **Yes / No** Aspirin **Yes / No** Dental Anesthetics **Yes / No** Codeine **Yes / No** Sulfa

Do you have any known allergies (latex, nickel, nuts, etc.)? Y / N Please specify:_____

Have you been hospitalized or had any surgeries? Y / N Please specify:_____

Do you have any history of these?:

Yes / No Heart attack / Stroke	Yes / No Sinus Problems	Yes / No Heart Disorder/Murmur/Defects	Yes / No Hepatitis or Liver Disorder
Yes / No Anemia / Bleeding Disorders	Yes / No Difficulty Breathing	Yes / No Artificial valves	Yes / No Kidney or Bladder Disorder
Yes / No Prolonged Bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Hypertension	Yes / No Ulcers / Colitis
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Congenital Heart Disease	Yes / No Pacemaker
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Heart Surgery	Yes / No Emotional Disorders
Yes / No Artificial Joints	Yes / No Neurologic Disorder	Yes / No Rheumatic Fever	Yes / No Hearing difficulties
Yes / No AIDS or HIV	Yes / No Cerebral Palsy	Yes / No Mitral Valve Prolapse	Yes / No Daily Aspirin / Blood Thinner
Yes / No Cancer / Chemotherapy / Radiation	Yes / No Convulsions/Seizures	Yes / No Endocrine/Hormone Disorders	Yes / No Pregnant (For women)
Yes / No Hearing Impairment	Yes / No Headaches	Yes / No Diabetes	_____ **Doctor's Initials**

If you are experiencing or have a history of any disease, condition, or problem not addressed, please explain:

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of parent or guardian : _____ **Date**: _____