COMPREHENSIVE DENTISTRY

1947 Citrona Drive ■ Fernandina Beach, Florida 32034 ■ T 904.261.7181 F 904.261.9797

www.ameliadental.com

Office use: Patient #

CHILD

PATIENT INFORMATION

Patient Last Name	Patient First Name	MI	Preferred Name / Nickname
Mailing Address	City	State	Zip Code
Home Phone		Cell Phone	Best time to call
Birth Date	SS #	Sex	
Whom may we thank for referring you to our office.		Name of other family members who are patients:	

RESPONSIBLE PARTY | (If patient is a minor, guardian who brings child is responsible)

Last Name	First Name	MI	
Mailing Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Birth Date	SS #	DL #	Relationship to Patient

DENTAL INSURANCE INFORMATION

Policy Holder Last Name	First Name	MI	
Mailing Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Birth Date	SS #	DL #	Relationship to Patient
Employer	Insurance Company		
Complete mailing address of Insurance Company			
Telephone Number of Insurance Company	Group #	Subscriber ID	

Office use: Patient # | | PATIENT NAME ______________________

THERE ARE MANY MEDICAL SITUATIONS WHICH CAN AFFECT OR BE AFFECTED BY PROCEDURES OR DRUGS USED FOR DENTISTRY. THEREFORE, PLEASE FILL OUT THE FOLLOWING CAREFULLY. THANK YOU.

Date of last medical exam	Physician's Name	Phone

CHILD

MEDICAL HISTORY

PLEASE CIRCLE IF YOUR CHILD HAS OR HAS HAD ANY OF THE FOLLOWING:

Heart Disease/Surgery	Leukemia	Chronic Fatigue	Eating Disorder
Irregular Heart Beat	Lung Disease	Diabetes	Sleep Apnea/Snoring
Congenital Heart Disorder	Asthma	Liver Disease	Hearing Disorder
Bacterial Endocarditis	Breathing Problem	Hepatitis	Speech Disorder
Rheumatic Fever	Chronic Adenoid/Tonsil Infections	Kidney Disease/Dialysis	Eye Disorder
Artificial Heart Valve	Tuberculosis	Thyroid Disease	Birth Defect
Pacemaker	Hayfever/Allergies	Autism	Handicaps/Disabilities
Stroke	Sinus Troubles	Neurological Problem	Cleft Lip/Palate
Low Blood Pressure	Cancer	Cerebral Palsy	Latex Allergy
High Blood Pressure	Radiation Treatment	Epilepsy/Seizures	Metal Allergy
Bruise Easy/Blood Disease	Chemotherapy	Fainting/Dizzy Spells	Herpes
Excessive Bleeding	Ulcer/Colitis	ADD/ADHD	HIV+
Anemia	Chronic Diarrhea	Depression	Excessive Thirst
Hemophilia	Acid Reflux	Psychiatric Care	Dry Mouth

Is child allergic to any medicine or local anesthetic? ❑ Yes ❑ No If yes, please list:	
Is child taking any medications? ❑ Yes ❑ No If yes, please list:	
Is child currently receiving medical treatment? ❑ Yes ❑ No If yes, please list:	
Is there any other medical information which should be known?	
Date of last dental exam	Any previous major dental treatment? ❑ Yes ❑ No If yes, when?

DOES YOUR CHILD HAVE OR HAVE HAD ANY OF THE FOLLOWING? - CHECK YES OR NO

❑ Yes	❑ No	Bad Breath	❑ Yes	❑ No	Sensitive teeth
❑ Yes	❑ No	Bleeding gums	❑ Yes	❑ No	Fingernail biting
❑ Yes	❑ No	Mouth breathing	❑ Yes	❑ No	Thumb/pacifier habit
❑ Yes	❑ No	Clinching or grinding	❑ Yes	❑ No	Excessive gagging
❑ Yes	❑ No	Pain around ear	❑ Yes	❑ No	Orthodontic treatment
❑ Yes	❑ No	Jaw popping	❑ Yes	❑ No	Fluoride supplements/rinse
❑ Yes	❑ No	Swelling/lumps in mouth	❑ Yes	❑ No	Fluoridated water
❑ Yes	❑ No	Frequent mouth ulcers	❑ Yes	❑ No	Fluoridated toothpaste
❑ Yes	❑ No	Unfavorable dental experiences	❑ Yes	❑ No	High sugar diet
❑ Yes	❑ No	Complications from extractions			

Please answer the following:

What is the texture of your child's toothbrush? ______________________

How often does your child brush? ______________________

How often does your child floss? ______________________

Reason for seeking a new dentist? ______________________

Any concerns about child's teeth/smile? ______________________

Appointments you select are reserved especially for you. Since "late cancellations" and "no shows" deny other patients the opportunity to schedule needed care, cancellations less than 24 hours in advance may be charged a cancellation/no show fee.

I hereby certify that the information provided on this form is true and correct.

Signature ______________________ Date: ______________________

Reviewed by: ______________________ DDS / DMD Date: ______________________