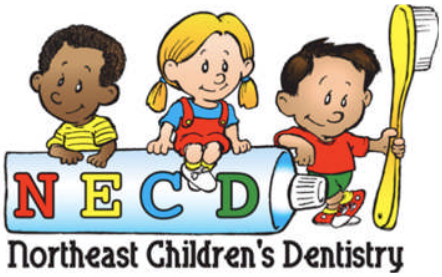

Northeast Location
8606 Village Drive, Suite B
San Antonio, TX 78217
Phone: 210-654-6882

Northern Oaks Location
4358 Thousand Oaks
San Antonio, TX 78217
Phone: 210-656-4300

Downtown Location
315 N. San Saba, Suite 202
San Antonio, TX 78207
Phone: 210-223-3383

Schertz Location
5000 Schertz Parkway, Suite 301
Schertz, TX 78154
Phone: 210-659-8000

Dominion Crossing Location
21727 IH-10 West, Ste. 203
San Antonio, TX 78257
Phone: 210-314-4545

Patient Information

Child's Name_____ Nickname_____
Last First MI

Date of Birth_____ Age _____ Gender: ☐Female ☐Male

Medicaid or Texas CHIP? ☐ Yes ☐ No ID#_____

Home Address_____ City_____ State _____ Zip _____

Family Information

Who is Accompanying Your Child Today?_____ Relationship_____

Do you have legal custody of this child? ☐Yes ☐No Is your child adopted? ☐Yes ☐No

Child primarily lives with: ☐Both Parents ☐Mother ☐Father Other _____

Parent(s) /Guardian(s) are: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnership

Other children seen by us? ☐ Yes ☐ No If yes, Name(s)_____

Nearest Relative not living with you_____ Phone Number_____

Do you or any family member have a dental background or employed in the dental field? ☐Yes ☐No
If yes, please explain_____

Parent / Guardian's Name_____
Last First Relationship

Birthdate_____ SSN_____ Driver's License_____ State:_____

Email:_____

Phone: Home_____ Work_____ Ext_____ Cell_____

Address: (☐same as above)

Street_____City_____ State_____ Zip _____

Employer:_____ Language Spoken_____

Parent / Guardian's Name _____
Last First Relationship

Birthdate_____ SSN_____ Driver's License_____ State:_____

Email:_____

Phone: Home_____ Work_____ Ext_____ Cell_____

Address: (☐same as above)

Street_____City_____ State_____ Zip _____

Employer:_____ Language Spoken_____

Consent

I give my consent for my child to have a dental check-up today along with a teeth cleaning, fluoride treatment, and any necessary x-rays. (Must be signed by a biological parent *or* legal guardian)

Signature_____ **Relationship to patient** _____ **Date**_____

Referral Information

How did you hear about our office? ☐ Internet ☐ Insurance Company ☐ School ☐ Work ☐ Sign
☐Previous Patient of Record ☐ Another patient, Friend _____ /Relative_____
☐ Pediatrician_____ ☐ Dental Office_____

Child's Name_____ **Date of Birth**_____ **Age**_____ **Medicaid ID#** _____

Reason for today's visit: ☐ First Visit to a Dentist ☐Check Up ☐ Cavity ☐ Pain ☐ Accident ☐ Other_____

Name of Previous Dentist_____ **Date of Last Visit** _____**For what service:**_____

Dental History

What is your child's attitude toward visiting the dentist? ☐Positive ☐Neutral ☐Negative

1. Has child complained about dental problems? ☐Yes ☐No If yes, explain_____
2. Has your child had any unhappy dental experiences? ☐Yes ☐No If yes, explain_____
3. Has your child had any injury to mouth, head or teeth? ☐Yes ☐No If yes, explain_____
4. Does your child brush teeth daily? ☐Yes ☐No Is floss used? ☐Yes ☐No ☐Sometimes
5. Do YOU assist child with tooth brushing? ☐Yes ☐No How often?_____

Does your child have any of the following mouth habits: ☐Thumb / Finger Sucking ☐Nail Biting ☐Mouth Breathing ☐Pacifier ☐Lip Biting / Sucking ☐Speech Impairment ☐Other_____

Is child currently ☐ Nursing ☐ Bottle Fed ☐ G-Tube Fed ☐ None

Medical History

Child's Physician_____Address_____Phone_____

Date of last physical examination_____Results_____

	Yes	No		Yes	No
Is child under the care of a physician now? If yes, reason:_____	☐	☐	**Are there any other allergies: Latex-Metal Food -Pollen - Animals-Dust-Dye-Other?** If yes, what:_____	☐	☐
Is child receiving medication or drugs? If yes, what:_____	☐	☐	**Has your child ever had a blood transfusion?** _____	☐	☐
Has child ever been hospitalized? If yes, reason:_____	☐	☐	**Are there any emotional problems**? If yes, what:_____	☐	☐
Has child ever had surgery? If yes, reason:_____	☐	☐	**Has child had any reactions to Anesthetics, Local and/or General?**_____	☐	☐
Is there any allergy to penicillin or other drugs? If yes, what:_____	☐	☐	**Has child had any reaction to Sedative Agents?** If yes, what:_____	☐	☐

Has this child had any treatment on any of the following? Please check Yes or No

Yes	No		Yes	No		Yes	No	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Endocrine Glands	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Skin

Has this child ever been diagnosed as having any of the following conditions? Please check Yes or No

Yes	No		Yes	No		Yes	No	
☐	☐	ADD / ADHD	☐	☐	Emotional Disorder	☐	☐	Pneumonia
☐	☐	AIDS / HIV	☐	☐	Epilepsy/Seizures	☐	☐	Pregnancy
☐	☐	Anemia	☐	☐	Eye Problems	☐	☐	Rheumatic Fever
☐	☐	Allergy	☐	☐	Excessive Bleeding Problem	☐	☐	Scarlet Fever
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Scoliosis
☐	☐	Asthma	☐	☐	Hearing Loss	☐	☐	Sickle Cell Anemia
☐	☐	Autism Spectrum Disorder	☐	☐	Heart Disease/Heart Murmur	☐	☐	Sinus Problems
☐	☐	Brain Injury	☐	☐	Hemophilia	☐	☐	Sleep Apnea
☐	☐	Bronchitis	☐	☐	Hepatitis – Type___	☐	☐	Snoring at Night
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Sore Throats - Frequent
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Spina Bifida
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Syndrome_____
☐	☐	Cleft Lip- Palate	☐	☐	MRSA	☐	☐	Tetanus
☐	☐	Congenital Birth Defect	☐	☐	Mumps	☐	☐	Tuberculosis
☐	☐	Developmentally Delayed	☐	☐	Mouth Breathing	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Nutritional Deficiency	☐	☐	Whooping Cough
☐	☐	Drug, Alcohol, Tobacco Use	☐	☐	Orthopedic Problems	☐	☐	Other_____

Is there anything else that you think we should know about your child?_____

I certify that I have read and understand the above questions. I will not hold Northeast Children's Dentistry, Inc. or any member of its staff responsible for any errors or omissions I may have made in the completion of this form. I authorize the release of information to all of my insurance companies. I understand that I am responsible for all financial responsibilities.

Signature_____ **Relationship to patient** _____**Date**_____