John Fasbinder, DDS: Dental Surgery & Anesthesia

PATIENT (under 18 years old) INFORMATION FORM: (PLEASE PRINT)

TODAY'S DATE: _____

Child's Name: _____ Nickname: _____ ☐ Male ☐ Female
FIRST MI LAST

Birthdate : _____ Age : ____ Social Security #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State : _____ Zip: _____

PERSON ACCOMPANYING THE CHILD TODAY:

Name: _____ Relation: _____ Phone #: _____

Do You Have Legal Custody of this Child? ☐ YES ☐ NO How Did You Hear About Us?: _____

Other Family Members Seen By Us: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Mother's Information: ☐ Step Mother ☐ Guardian	Father's Information: ☐ Step Father ☐ Guardian
Name: _____ Birthdate: _____	Name: _____ Birthdate: _____
Email Address: _____	Email Address: _____
Cell #: _____ Home #: _____	Cell #: _____ Home #: _____
Employer: _____ Work #: _____	Employer: _____ Work #: _____
SS #: _____ DL #: _____	SS #: _____ DL #: _____

RESPONSIBLE PARTY/INSURANCE INFORMATION:

Person Responsible for this Account: _____ Relation: _____
FIRST MI LAST

Address: _____ City: _____ State : _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #:_____ Union or Local #: _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ ***YES*** ☐ ***NO*** ***IF YES, PLEASE COMPLETE THE FOLLOWING:***

Name of Insured: _____ Relation: _____
FIRST MI LAST

Address: _____ City: _____ State : _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #:_____ Union or Local #: _____

I certify that I have read and understand the questions asked in this Patient (18 Years or Younger) Information section and the Patient (18 Years or Younger) Medical History section on the back side of this form. To the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to this child's health. It is my responsibility to inform the office of any changes to this child's medical status. I authorize the dental staff to perform the necessary dental services that this child may need.

Sign here: _____ Date: _____
Parent or Guardian

Is there a Guardian? ☐ **YES** ☐ **NO** *If YES, a copy of Guardianship Papers and DPOA (Durable Power of Attorney) are needed.*

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PATIENT (under 18 years old) MEDICAL HISTORY: (PLEASE PRINT)

Child's Name: _____ Birthdate : _____
FIRST MI LAST

Primary Care Physician/Clinic Name: _____ Clinic Phone #: _____ Date of Last Visit: _____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Reason for Your Child's Visit Today: _____

		YES	NO
1.	Is your child under medical treatment now?		
2.	Has your child ever been hospitalized for any surgical operations or serious illness?		

3.	Please write any serious medical problems that the child has had:

Is your child Allergic to or has he/she had any reactions to the following?

	YES	NO
Aspirin		
Barbiturates		
Codeine		
Iodine		

	YES	NO
Latex		
Local Anesthetics (ex., Novocaine)		
Metals/Nickel		
Penicillin or other Antibiotics		

	YES	NO
Plastic		
Sulfa Drugs		
Other (list below):		

Is your child taking any medication(s) including non-prescription medicine/supplements? ☐ ***YES*** ☐ ***NO*** ***IF YES, PLEASE LIST BELOW:***

Name of Medicine/Supplement	Dosage/Frequency

Name of Medicine/Supplement	Dosage/Frequency

Does your child currently have or have had any of the following?

	YES	NO
Abnormal Bleeding		
ADD/ ADHD		
AIDS or HIV		
Anemia		
Artificial Bones/Joints		
Asthma		
Cancer		
Congenital Heart Defect		
Diabetes		
Epilepsy/Convulsions		
Fainting/Seizures		
Frequently Tired		
Handicaps/Disabilities		

	YES	NO
Hay Fever/ Allergies		
Hearing Impairment		
Heart Disease		
Heart Murmur		
Heart Trouble		
Hemophilia		
Hepatitis/ Jaundice		
Kidney Diseases		
Leukemia		
Liver Disease		
Radiation Therapy		
Respiratory Problems		
Rheumatic/Scarlet Fever		

	YES	NO
Sexually Transmitted Disease		
Sickle Cell Disease/Traits		
Special Needs		
Stomach Troubles/ Ulcers		
Tuberculosis		
Unexplained Weight Loss		
Other:		

OFFICE USE ONLY

PATIENT DENTAL HISTORY

		YES	NO
1.	Does your child brush his/her teeth daily?		
2.	Does your child floss his/her teeth daily?		
3.	Do your child's gums bleed while brushing or flossing?		
4.	Has your child ever had a serious/difficult problem associated with previous dental work?		
5.	Is the child's water fluoridated?		
6.	Is the child taking fluoridated supplements?		
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking?		
	Pain (joint, ear, side of face?)		
	Difficulty in opening or closing?		
	Difficulty in chewing?		

		YES	NO
8.	Does/did your child's tongue thrust?		
9.	Does/did your child clench or grind his/her teeth?		
10.	Does/did your child breathe through his/her mouth?		
11.	Does/did your child have nursing bottle habits?		
12.	Does/did your child suck on his/her thumb or finger?		
13.	Does/did your child have speech problems?		
14.	Does/did your child bite or suck his/her lips or cheeks frequently?		
15.	Does/did your child bite his/her nails?		

Does your child have any special needs? Do you have any other concerns?

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. 12/15/11