Modern Smile Dental

901 Russell Avenue
Suite 100
Gaithersburg, MD. 20879
(301) 977-8640

Date: _____

Name of minor/child_____

Sex please circle: MALE Female AGE: _____ Birth date: _____

Child's Social Security #_____ Email: _____

Child's Home Address:_____

Person financially responsible_____ Relationship to child_____

Billing address (if different than above)_____

Home phone: _____ Email: _____

Whom may we thank for referring you? _____

Father's Name_____ Address (if different from patient's) _____ _____ Home Phone_____ Work Phone_____ Employer_____ SS#_____DOB_____ Dental Insurance_____ Insurance Phone#_____ Policy #_____ Group#_____ Secondary Dental Insurance?_____	Mother's Name_____ Address (if different from patient's) _____ _____ Home Phone_____ Work Phone_____ Employer_____ SS#_____DOB_____ Dental Insurance_____ Insurance Phone#_____ Policy #_____ Group#_____ Secondary Dental Insurance?_____

Dental History

Has the child complained about any dental problems?	YES	NO	Is fluoride taken in any form?	YES	NO
Does the child brush daily?	YES	NO	Id the child's water fluoridated?	YES	NO
Does the child floss daily?	YES	NO	Any injuries to mouth, teeth, head?	YES	NO
Nail Biting?	YES	NO	Any unhappy dental experiences?	YES	NO
Nursing bottle habits?	YES	NO	Thumb sucking / finger sucking?	YES	NO
Any pain/tenderness in jaw or joint area?	YES	NO	Lip sucking / biting?	YES	NO

Minor / Child's physician_____

City / State_____Phone_____

Date of last physical examination_____ Results_____

Patient Name:_____

Medical History

Is minor / child under care of physician now?	YES	NO	Please list all medication child is currently taking: _____
Receiving any medication or drugs?	YES	NO	_____
Ever been hospitalized?	YES	NO	Please list all allergies:_____
Ever had surgery?	YES	NO	_____
Is there excessive bleeding when cut?	YES	NO	_____
Ever been told to Pre-medicate? Pre-med with?_____	YES	NO	Additional info: _____
Is the child allergic to latex?	YES	NO	_____
			_____

Abnormal bleeding	YES	NO	Diabetes	YES	NO
AIDS/HIV	YES	NO	Epilepsy	YES	NO
Anemia	YES	NO	Fainting	YES	NO
Asthma	YES	NO	Handicaps or Disabilities	YES	NO
Bladder problems	YES	NO	Hearing impairment	YES	NO
Cancer	YES	NO	Heart Murmur	YES	NO
Cerebral Palsy	YES	NO	Heart problems	YES	NO
Chicken Pox	YES	NO	Hemophilia	YES	NO
Congenital Heart Defect	YES	NO	Hepatitis	YES	NO
Convulsions	YES	NO	Kidney/liver problems	YES	NO
Measles	YES	NO	Thyroid disease	YES	NO
Mononucleosis	YES	NO	Tuberculosis	YES	NO
Mumps	YES	NO	Sinus problems	YES	NO
Rheumatic fever	YES	NO			

Please discuss any medical problems that the child has:_____

_____

In the event of an emergency, whom should we contact?

Name: _____ Relationship_____ Phone_____

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 authorizer the dental staff to perform the necessary dental services my child may need.

Signature_____ Date_____

Dentist signature_____ Date_____