



Patient Information

Tell Us About Your Child

Today's Date	Child's Home # (____)
Child's Name	Child's Home Address
Last First MI	
Nickname	Apt#
<input type="checkbox"/> Male <input type="checkbox"/> Female	
Birthdate	Child's Age
School	Grade
	City State Zip
	With whom does the child reside?

Who Is Accompanying The Child Today?

Name	Relation
Do you have legal custody	<input type="checkbox"/> Yes <input type="checkbox"/> No
Whom may we thank for referring you?	Other family members seen by us?
Has this child been seen by Dr. Erickson before?	Date & Name of last dental procedure:
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Mother's Information

<input type="checkbox"/> Biological Mother	<input type="checkbox"/> Step Mother	<input type="checkbox"/> Guardian
Name	Birthdate	Cell #
Employer	SS#	Wk# Ext.
		Home#

Father's Information

<input type="checkbox"/> Biological Father	<input type="checkbox"/> Step Father	<input type="checkbox"/> Guardian
Name	Birthdate	Cell #
Employer	SS#	Wk# Ext.
		Home#

Person Responsible for Account

Name	Relation	Home #	Work #
Billing Address		Email	
City		Employer	
State	Zip	Emergency Contact Phone	

Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Group # _____
Member ID# _____
Policy Owner's Name _____
Relationship to Patient _____

Policy Owner's Birthdate _____
Policy Owner's SS# _____
Policy Owner's Employer _____
If military, what is the rank of the subscriber? _____
Orthodontic Coverage? Yes No
If child does not have dental insurance, how do you intend to pay?
 Cash Check MasterCard Visa

Medical Narrative

Is your child:

Under the care of a doctor at the present time?
 No Yes When/why? _____
Taking any medication at the present time?
 No Yes What? _____
Allergic to any medications?
 No Yes What? _____

Allergic to any foods, materials or dyes?
 No Yes What? _____
Up to date with immunizations?
 Yes No

Has your child:

Had general anesthesia? No Yes
Had any complications with general anesthesia?
 No Never had general anesthesia
 Yes Please explain _____
Had any surgeries?
 No Yes When/why? _____

Ever been a patient at the emergency room?
 No Yes When/why? _____
Ever been hospitalized as a patient?
 No Yes When/why? _____

Has your child ever had any of the following problems?

Abnormal Bleeding Yes No
ADD/ADHD Yes No
Allergies Yes No
Anemia Yes No
Anaphalaxis Yes No
Artificial Heart Valve/Joint* Yes No
Asthma Yes No
Autism Yes No
Behavioral Problems Yes No
Blood Transfusion Yes No
Cancer Yes No
Chemotherapy/Radiation Yes No
Congenital Heart Defect* Yes No
Convulsions/Epilepsy Yes No
Diabetes Yes No
Frequent Nose Bleeds Yes No
Handicaps/Disabilities Yes No
Hearing/Speech Impairment Yes No
Heart Murmur* Yes No
Hemophelia Yes No
Hepatitis Yes No
High Blood Pressure Yes No

HIV+/AIDS Yes No
Kidney Liver Problems Yes No
Learning Disability Yes No
Leukemia Yes No
Malignant Hyperthermia Yes No
Mitral Valve Prolapse* Yes No
Organ Transplant Yes No
Pacemaker* Yes No
Pregnancy Yes No
Renal Dialysis Yes No
Rheumatic/Scarlet Fever* Yes No
Sickle Cell Disease/Trait Yes No
Tuberculosis (TB) Yes No

If any of the above are checked, please give a brief explanation: _____

Does your child have any other disease, condition, or medical problem not mentioned above? Yes No

If yes, please list _____

Physician/Pediatrician Information

Physician/Pediatrician Name _____
Address _____
Phone _____ Fax _____
E-mail Address _____
Date of last regular check-up _____
Date of last medical visit _____
Reason _____

Please list other specialists your child is seeing:
Name _____
City _____ Phone _____
Name _____
City _____ Phone _____
Name _____
City _____ Phone _____

Family-Sibling History

Are you aware of any hereditary medical conditions from the father's side?
 Yes No Don't know
If yes, please explain _____

Are you aware of any hereditary medical conditions from the mother's side?
 Yes No Don't know
If yes, please explain _____

Dental History

Reason your child is here today _____
Is this your child's first dental visit?
 Yes No
Date of last visit _____
Were X-Rays taken? Yes No
Has your child had an unfavorable experience in a dental office?
 Yes No
If yes, please explain _____
Child's previous dentist _____
City _____ Phone _____

What is your water source?
 Private Well Public System
Does your child suck their thumb or finger? Yes No
Does your child use a pacifier? Yes No
Was your child bottle fed? Yes No
Age discontinued? _____
Has your child ever had trauma to their teeth? Yes No
Do you assist your child with tooth brushing? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date _____

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