Patient Information

Today's Date: _____

Name: _____ Date of Birth: ____/____/____ M___ F___

Address: _____
Street City State Zip

Primary Phone: _____ Alternate Phone: _____

Social Security #: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Email Address: _____

Employer/School: _____

Whom May We Thank for Referring You? _____

Responsible Party Information

Responsible Party (if different from patient): _____

Date of Birth: _____ Social Security #: _____

Employer: _____

Dental Insurance Information

Subscriber's Name: _____ Subscriber ID# _____

Subscriber Date of Birth: _____ Social Security #: _____

Insurance Company: _____ Employer: _____

Ins Phone: _____ Group #: _____

Is the patient covered by any other dental insurance? Yes No

Secondary Subscriber Name: _____ Subscriber ID# _____

Subscriber Date of Birth: _____ Social Security #: _____

Insurance Company: _____ Employer: _____

Ins Phone: _____ Group #: _____

Dr. Rebecca Tolley Jordan DDS

Child Medical/Dental History (updated 2018)

Patient Name: Birth Date: Date Created:

What brings you into our office today?

Dental Health

Is your child in Good Health?	◯ Yes ◯ No	
Has your child been evaluated or had orthodontic treatment before?	◯ Yes ◯ No	If yes
Has there been any injury to the mouth, face, teeth or chin?	◯ Yes ◯ No	If yes
Are you aware of any missing teeth or extra permanent teeth?	◯ Yes ◯ No	If yes
Has your child ever had any noise, pain, stiffness or difficulty opening in the jaw joint? (TMD/TMJ?)	◯ Yes ◯ No	If yes
Does your child brush their teeth daily?	◯ Yes ◯ No	If yes
Does you child breathe through their nose?	◯ Yes ◯ No	
Does your child have allergies? Please specify	◯ Yes ◯ No	If yes
Has your child had adenoids or tonsils removed?	◯ Yes ◯ No	
Is your child under the care of a physician?	◯ Yes ◯ No	If yes
Is your child currently taking any medications?	◯ Yes ◯ No	If yes

Physician Information

Physician Contact Information	☐	If yes
Please List Any Specialists Seen	☐	If yes

Medical History

Has your child ever had any of the following medical problems?

Abnormal Bleeding	◯ Yes ◯ No	Allergy to Metal/Latex	◯ Yes ◯ No	Allergy to Plastics	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Cancer/Chemo/Radiation Therapy	◯ Yes ◯ No
Congenital Heart Defect	◯ Yes ◯ No	Convulsions/Seizures	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Disability/Handicap	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Hemophilia/Bleeding Disorder	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No
Jaundice/Liver Disease	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Kidney problems	◯ Yes ◯ No
Need for Premedication	◯ Yes ◯ No	Rheumatic/Scarlet Fever	◯ Yes ◯ No	Severe/Frequent Headaches	◯ Yes ◯ No
Sinus Problems	◯ Yes ◯ No	Speech Problems/Therapy	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Allergies	◯ Yes ◯ No				

Have you had any serious illness not listed here? ◯ Yes ◯ No If yes

I understand the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inf any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of Patient, Parent or Guardian:

X

Date:_____