



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: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any other allergies: Latex-Metal Food -Pollen - Animals-Dust-Dye-Other? If yes, what: _____	<input type="checkbox"/>	<input type="checkbox"/>
Is child receiving medication or drugs? If yes, what: _____	<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever had a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever been hospitalized? If yes, reason: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems? If yes, what: _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever had surgery? If yes, reason: _____	<input type="checkbox"/>	<input type="checkbox"/>	Has child had any reactions to Anesthetics, Local and/or General? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there any allergy to penicillin or other drugs? If yes, what: _____	<input type="checkbox"/>	<input type="checkbox"/>	Has child had any reaction to Sedative Agents? If yes, what: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Blood - Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal (stomach)	<input type="checkbox"/>	<input type="checkbox"/>	Muscles
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Glands	<input type="checkbox"/>	<input type="checkbox"/>	Kidney - Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System
<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Snoring at Night
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats - Frequent
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip- Palate	<input type="checkbox"/>	<input type="checkbox"/>	MRSA	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Birth Defect	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Delayed	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	<input type="checkbox"/>	Drug, Alcohol, Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	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 _____