


HOLDEN
DENTAL CARE


PATIENT INFORMATION

Name:_____ MI_____ Today's Date:_____

Preferred Name:_____ Gender: M F Date of Birth:_____ Age:_____

Parent/Guardian Name _____ Occupation _____

Address:_____

City:_____ State:_____ Zip:_____

E-Mail:_____ I would like e-mail appointment reminders Yes__ No__

Home (_____)_____ Cell(_____)_____

School:_____ School Phone (_____)_____

Guardian Employer/Address:_____ Work (_____)_____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name:_____ Relation:_____ Phone(_____)_____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name:_____ Preferred Name:_____

Gender: M F Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Home (_____)_____ Cell(_____)_____ Spouse: (_____)_____

Employer / School:_____ Work (_____)_____

Employer/Address:_____

DENTAL HISTORY

Date of last dental visit? _____ For what service? _____

Please circle "yes" or "no" to indicate if child has had any of the following:

Has child complained about dental problems?	Yes No	Does child brush teeth daily?	Yes No
Does child floss teeth daily?	Yes No	Is fluoride taken in any form?	Yes No
Any injuries to mouth, teeth, head?	Yes No	Any unhappy dental experiences?	Yes No

Any mouth habit - thumb-sucking, nail biting, mouth breathing, snoring, pacifier, sleeping with bottle, etc?

If yes, Please circle and explain: _____

_____

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (_____)_____

Date of last physical examination _____ Results _____

Is Minor/Child under care of a physician now?	Yes No	Medications_____
Receiving any medication or drugs?	Yes No	_____
Is there excessive bleeding when cut?	Yes No	_____
Ever been hospitalized?	Yes No	Allergies _____
Ever had surgery?	Yes No	_____

If any of the above is yes, Please explain: _____

_____

Please circle "yes" or "no" to indicate if child has had or has had difficulty with any of the following:

Aids	Yes No	Drug/Alcohol Abuse	Yes No	Mononucleosis	Yes No
Anemia	Yes No	Epilepsy	Yes No	Mouth Breathing	Yes No
Asthma	Yes No	Fainting	Yes No	Mumps	Yes No
Bladder Problems	Yes No	Hearing Problems	Yes No	Rheumatic Fever	Yes No
Cancer	Yes No	Heart Problems	Yes No	Sinus Problems	Yes No
Cerebral Palsy	Yes No	Hepatitis	Yes No	Snoring	Yes No
Chicken Pox	Yes No	Kidney Disease	Yes No	Thyroid Disease	Yes No
Convulsions	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Diabetes	Yes No	Measles	Yes No	Other _____	

For Office Use Only:

Reviewed By:_____ Date: _____

EMERGENCY CONTACT

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

Name _____ Relationship _____ Phone (_____)_____

Name _____ Relationship _____ Phone (_____)_____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct.
I understand that is my responsibility to inform my doctor if my minor/child ever has a change in health.

I am the parent, guardian, or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date