MICHAEL BARNO, DMD
CHRIS ROBNETT, DMD
NICOLE ANDREINI, DDS, MS

Child's Name ______________________________ **Today's Date** ______________________________

Nickname____________________ **Age** __________ **Date of Birth**__________________ **Gender** __________

Address ________________________________ **City** ______________ **State** ______ **Zip Code** ____________

Social Security Number ______________________ **School** ______________________ **Grade** ____________

Mother's Information: **Name** ____________________________ **Employer** __________________________

Social Security Number________________________ **Email** ______________________________________

Home #______________________ **Cell #** ______________________ **Work #**______________________

Father's Information: **Name** ______________________________ **Employer** __________________________

Social Security Number________________________ **Email** ______________________________________

Home #______________________ **Cell #** ______________________ **Work #**______________________

Person financially responsible (*if other than parent*)__________________________ **Relationship** ____________

Has any other member of your family been treated here? (name) ______________________________________

Whom may we thank for referring you? ____

DENTAL INSURANCE INFORMATION

Insurance Subscriber's Name ______________________________ **Subscriber's SS# or ID#** __________________

Subscriber's Date of Birth__________ **Subscriber's Employer** __________________ **Relationship to patient**_______

Dental Insurance Company ____________________**Group #**__________**Phone Number** __________________

DENTAL HISTORY

Date of last dental visit ____________________________ **For what service?**__________________________

Has child complained of any dental problems? ____

Has parent noticed any dental problems? ____

Any unhappy dental experiences? ____

Any mouth habits? (*e.g. thumb sucking, mouth breathing, etc*) ____________________________________

Is your child now wearing or ever worn Orthodontic (braces) appliances? __________________________

Does your child brush daily? ______________ **Do you assist while brushing?** ____________

Child's attitude to dentistry?____

Has child ever had dental x-rays? ____________________________ **Panorex x-ray?** ______________________

BRICKYARD DENTAL GROUP

MICHAEL BARNO, DMD
CHRIS ROBNETT, DMD
NICOLE ANDREINI, DDS, MS

HEALTH HISTORY

Child's Physician ____ **Phone #**____________________

Date of last physical examination ____________________ **Results** ________________________________

Please list any medication allergies ____

Any other allergies? (*e.g. Latex, food, pollen, animals, dust, etc*) ________________________________

Is child under the care of physician now? If yes, please explain ________________________________

Is child taking any medication? If yes, please list current medications________________________________

Has child ever been hospitalized? If yes, please explain________________________________

Has child ever had surgery? If yes, please explain________________________________

PLEASE CIRCLE IF THE CHILD HAS OR HAS EVER HAD ANY DIFFICULTY WITH THE FOLLOWING:

ADHD   Anemia   Asthma   Bladder   Blood/Bleeding Disorder   Cancer

Cerebral Palsy   Chronis Sinus   Diabetes   Epilepsy   Fainting   Hearing   Heart

HIV   Kidney   Liver   Mononucleosis   Reflux   Seizures   Thyroid

Tuberculosis   Other ______________________

Does child have good physical coordination?____

Are there any emotional problems? ____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed. ________________________________

____

____

I understand that payment for any and all services rendered are my responsibility. If I have dental insurance, I understand also that any and all fees or portions of fees for services rendered that are not paid for by my dental insurance company are my responsibility.

Signature of parent or guardian ______________________________ Relationship to child ____________