Welcome to our office! WE ARE GLAD YOU ARE HERE! If you have any questions at any time, please feel free to ask us.

Personal Information:

Patient's Name ____

Address ____

City ______________________________ State ______________ Zip ____________

Sex ________________ Age ____________ Birthdate ______________________

Whom may we thank for referring you to our office? ________________________

Legal Mother ____

SSN __________________________________ Birthdate ________________

Cell phone ________________________Home phone ____________________

Occupation/Employer ______________________________Work phone ______________

Home address (if different from above) ______________________________________

Legal Father ____

SSN __________________________________ Birthdate ________________

Cell phone ________________________Home phone ____________________

Occupation/Employer ______________________________Work phone______________

Home address (if different from above) ______________________________________
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Nearest relative to contact about appointments if you cannot be reached________________________

Relationship to child____________________ Cell or home phone __________________
****

What are your primary dental concerns?

____

What are your primary medical concerns?

____

HOW CAN WE HELP YOU HELP YOUR CHILDREN ACHIEVE YOUR DENTAL, ORTHODONTIC, OR HEALTH GOALS?

CONSENT: Your child is a minor; therefore it is necessary that a signed permission statement be obtained from a parent or guardian before any dental service can be performed.
I authorize Dr. Alexis Collins and Dr. James Nyland and staff to provide my child's dental examination and treatment, including the use of Nitrous Oxide relaxation sedation as indicated by Dr. Alexis Collins and Dr. James Nyland for the comfort of my child.

____ ______________________

Signature of Parent or Guardian Date

Patient's Name ____ **Date** _____________________

Physician's Name/Phone____ Child's Birthdate ___________

Other Health Professionals' Names and Specialties ____

Has the **patient** had any of the following? (please check and explain)

YES	Or NO	
___	___	Preterm birth, if yes, was child intubated? ____________
___	___	AIDS/HIV Positive
___	___	Blood Disease or Disorder
___	___	Hemophilia
___	___	Rheumatic Fever
___	___	Heart Murmur
___	___	Heart Problems
___	___	Asthma (Dates of hospitalizations of Asthma: _______________)
		** If your child uses an inhaler, please bring to *ALL appointments.*
___	___	Obstructive Sleep Apnea
___	___	RSV / Breathing Problems
___	___	Allergies to Medications ___________________________
___	___	Latex Allergy
___	___	Allergies to Anesthetics (for example: Lidocaine or Benzocaine)
___	___	PABA Allergies
___	___	Nickel Allergy
___	___	Other Allergies(seasonal, food, dyes, etc): _____________________________________
___	___	Hepatitis
___	___	Kidney or Liver Disease
___	___	Diabetes
___	___	Cancer
___	___	Malignant Hyperthermia
___	___	Sickle Cell Anemia
___	___	Epilepsy/Seizures/Cerebral Palsy/Hydrocephalus with shunt
___	___	Tuberculosis: Dates of Active Treatment _______________
___	___	Autism
___	___	Developmentally Delayed
___	___	Anemia: please describe __________________________
___	___	Eating or Digestive Disorder
___	___	Headaches
___	___	Fainting
___	___	Tobacco Habit
___	___	Skin rash or ring worm
___	___	Herpes or cold sores

FOR OFFICE USE

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Females Only:

___	___	Pregnancy
___	___	Birth Control Pills

Any other medical conditions or concerns (past or present)?

____

List any medications (prescription or over the counter) ____

Any significant hospitalizations? (Describe) ____

Is your child's drinking water fluoridated? YES _____ NO _____ UNCERTAIN _________

If No, is your child using a fluoride supplement? Yes ________ No ________

Do you have any health problems that need further clarification? YES ____ No ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any change in his/her health, I will inform Drs. Collins and Nyland at the next appointment without fail.

Signature of parent or guardian _____________________________________ Date ________________

11/13