

JUVENILE NEW PATIENT QUESTIONNAIRE

Child's Name _____ Date _____

Nickname _____ Sex _____

Birth date _____ Age _____ Social Security# _____

Address _____

Phone _____

CHILD'S HABITS

How often does your child brush? _____

How often does your child floss? _____

Does your child:

Suck thumb/finger _____ Date of last dental visit _____

Suck/bite lip _____ Previous dentist _____

Bite/chew nails _____ Child's Physician _____

Chew hard objects
(pencils, ect) _____ Phone # _____

Grind teeth _____ Is your child's water fluoridated? _____

Clench jaw _____ Does your child take fluoride supplements? _____

Has your child had difficulty with previous dental visits? _____

HEALTH HISTORY

Has your child had any of the following:

Asthma _____ Handicaps/disabilities _____

Cancer _____ Tuberculosis _____

Hepatitis _____ Diabetes _____

HIV/AIDS _____ Rheumatic Fever _____

Hemophilia _____ Congenital Heart Defect _____

Allergies _____ Heart Murmur _____

Abnormal Bleeding _____ Convulsions/Epilepsy _____

Any allergies to any medications? _____

Is your child on any medications? _____

RESPONSIBLE PARTY

Name _____ Relationship _____

Address _____ Phone _____

Are you covered by dental insurance? _____ Policy holder's name _____

Policy Holders SS# _____ Insurance company _____

Insurance address _____

How were you referred to our office? _____

Signature _____ Date _____