



AURENTZ

FAMILY DENTAL

DATE _____

| TELL US ABOUT YOUR CHILD | | |
|--------------------------|------|--------|
| Name | | |
| Social Security # | | |
| Gender | MALE | FEMALE |
| Date of Birth | | |
| Age | | |
| Home Address | | |
| | | |
| Phone Number | | |

| PRIMARY DENTAL INSURANCE | | |
|-----------------------------|---------|---------|
| Employer | | |
| Name of Policy Holder | | |
| Policy Holder Date of Birth | | |
| Policy Holder SS# | | |
| Relationship to Patient | | |
| Insurance Co. Name | | |
| | ID # | Group # |
| | Phone # | |
| Insurance Co. Address | | |



AURENTZ

FAMILY DENTAL

| FATHER'S INFORMATION | |
|----------------------|--|
| Name | |
| Social Security # | |
| Date of Birth | |
| Email | |
| Home Address | |
| | |
| Phone Number | |

| MOTHER'S INFORMATION | |
|----------------------|--|
| Name | |
| Social Security # | |
| Date of Birth | |
| Email | |
| Home Address | |
| | |
| Phone Number | |



| DENTAL HISTORY | |
|---|-----------------------------------|
| Previous Dentist | |
| Previous Dentist Address | |
| Date of Last Dental Visit | |
| Were X-Rays Taken | YES / NO If so, what type? |
| Has your child injured head, mouth, or teeth | YES / NO Please Explain |
| Is your child's water fluoridated? | YES / NO |
| Does your child take fluoride supplements? | YES / NO |
| Has your child had difficulty with previous dental visits? | YES / NO Please Explain |
| Are you aware of any problems with your child's mouth or teeth? | YES / NO Please Explain |
| Has your child ever pre-medicated for dental treatment? | YES / NO Please Explain |
| Comments/Questions | |



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| DENTAL HISTORY (CONFIDENTIAL) | | |
|---|---|-----------------------------|
| Does your child have a history of, or is your child currently doing any of the following? | | |
| Pacifier | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suck Thumb/Finger | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suck/Bite Lip | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bite/Chew Nails | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chew Hard Objects (pencils, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grind Teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was your child | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bottle Fed | <input type="checkbox"/> Yes When weaned: | <input type="checkbox"/> No |
| Breast Fed | <input type="checkbox"/> Yes When weaned: | <input type="checkbox"/> No |

| MEDICAL HISTORY (CONFIDENTIAL) | | |
|---|--|-----------------------------|
| Physician's Name: | Phone #: | |
| Date of Last Visit: | | |
| Previous Hospitalizations/ Surgeries/ Serious Illnesses: When? | | |
| Had a Blood Transfusion | <input type="checkbox"/> Yes When: | <input type="checkbox"/> No |
| Are immunizations up to date | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child taking any Medications: | <input type="checkbox"/> Yes Which Ones: | <input type="checkbox"/> No |
| Is your child Allergic to any medications? | <input type="checkbox"/> Yes Which Ones: | <input type="checkbox"/> No |
| Has your child ever developed any condition including bleeding, drug or anesthesia reaction or rash requiring special treatment after your last dental visit? | <input type="checkbox"/> Yes Please Explain: | <input type="checkbox"/> No |

| HEALTH HISTORY (CONFIDENTIAL) | | |
|--|--|---|
| Does your child have a Blood Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If you chose yes, please check the box that applies. | | |
| Anemia <input type="checkbox"/> Yes | | Von Willebrand <input type="checkbox"/> Yes |
| Hemophilia <input type="checkbox"/> Yes | | Sickle Cell <input type="checkbox"/> Yes |
| Excessive Bleeding <input type="checkbox"/> Yes | | |

If you answered yes to any of these, please explain: _____

| | | |
|---|--|---|
| Does your child have a Heart Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If you chose yes, please check the box that applies. | | |
| Artificial Valve <input type="checkbox"/> Yes | | High Blood Pressure <input type="checkbox"/> Yes |
| Congenital Heart Defect <input type="checkbox"/> Yes | | Low Blood Pressure <input type="checkbox"/> Yes |
| Heart Disease <input type="checkbox"/> Yes | | Heart Attack (Myocardial Infarction) <input type="checkbox"/> Yes |
| Heart Murmur (Irregular Heart Beat) <input type="checkbox"/> Yes | | Pacemaker <input type="checkbox"/> Yes |
| Rheumatic Fever <input type="checkbox"/> Yes | | Infective Endocarditis <input type="checkbox"/> Yes |
| Angina (Chest Pains) <input type="checkbox"/> Yes | | Mitral Valve Prolapse <input type="checkbox"/> Yes |

If you answered yes to any of these, please explain: _____

| | | |
|---|--|--|
| Does your child have a Respiratory Diseases/ Lung Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If you chose yes, please check the box that applies. | | |
| Asthma <input type="checkbox"/> Yes | | Persistent Cough <input type="checkbox"/> Yes |
| Breathing Difficulty <input type="checkbox"/> Yes | | Shortness of Breath <input type="checkbox"/> Yes |
| COPD <input type="checkbox"/> Yes | | Sleep Apnea <input type="checkbox"/> Yes |

If you answered yes to any of these, please explain: _____



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Cont. HEALTH HISTORY (CONFIDENTIAL)

| | | | | | |
|-------------------------------------|------------------------------|------------------------------|-----------------------------|--|--|
| Does your child have Special Needs? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If you chose yes, please check the box that applies. | |
| ADHD | <input type="checkbox"/> Yes | | Wheelchair | <input type="checkbox"/> Yes | |
| Behavior Disorder | <input type="checkbox"/> Yes | | Hearing Impairment | <input type="checkbox"/> Yes | |
| Autism | <input type="checkbox"/> Yes | | Head Injury | <input type="checkbox"/> Yes | |
| Depression | <input type="checkbox"/> Yes | | Developmental Challenges | <input type="checkbox"/> Yes | |
| Down Syndrome | <input type="checkbox"/> Yes | | Nervous Disorders | <input type="checkbox"/> Yes | |
| Cerebral Palsy | <input type="checkbox"/> Yes | | Psychological Disorders | <input type="checkbox"/> Yes | |
| Vision Impairment | <input type="checkbox"/> Yes | | Bipolar Depression | <input type="checkbox"/> Yes | |
| Spina Bifida | <input type="checkbox"/> Yes | | | | |

If you answered yes to any of these, please explain: _____

| | | | | | |
|---|------------------------------|------------------------------|-----------------------------|--|--|
| Does your child have an Infectious Disease? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If you chose yes, please check the box that applies. | |
| HIV/AIDS | <input type="checkbox"/> Yes | | STD | <input type="checkbox"/> Yes | |
| Hepatitis | <input type="checkbox"/> Yes | | Tuberculosis | <input type="checkbox"/> Yes | |
| Herpes | <input type="checkbox"/> Yes | | | | |

If you answered yes to any of these, please explain: _____

| | | | | | |
|--|------------------------------|------------------------------|-----------------------------|--|--|
| Does your child have Stomach Problems? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If you chose yes, please check the box that applies. | |
| Reflux | <input type="checkbox"/> Yes | | Ulcers | <input type="checkbox"/> Yes | |

If you answered yes to any of these, please explain: _____

| | | | | | |
|------------------------------------|------------------------------|------------------------------|-----------------------------|--|--|
| Does your child have Ear Problems? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If you chose yes, please check the box that applies. | |
| Ear Tubes | <input type="checkbox"/> Yes | | Recurrent Ear Infections | <input type="checkbox"/> Yes | |
| Hearing Loss | <input type="checkbox"/> Yes | | | | |

If you answered yes to any of these, please explain: _____

| | | | | | |
|-----------------------------------|------------------------------|------------------------------|-----------------------------|--|-----------|
| Does your child have/ had Cancer? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If you chose yes, please check the box that applies. | |
| Chemotherapy | <input type="checkbox"/> Yes | | Remission | <input type="checkbox"/> Yes | How Long? |
| Radiation | <input type="checkbox"/> Yes | | Leukemia | <input type="checkbox"/> Yes | |
| Tumors | <input type="checkbox"/> Yes | | | | |

If you answered yes to any of these, please explain: _____

| | | | | | |
|---|------------------------------|------------------------------|-----------------------------|--|-----------------------|
| Does your child have history of any of the conditions listed below? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If you chose yes, please check the box that applies. | |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes | | Liver Disease | <input type="checkbox"/> Yes | |
| Cleft Palate | <input type="checkbox"/> Yes | | Pregnancy | <input type="checkbox"/> Yes | What Trimester: _____ |
| Diabetes | <input type="checkbox"/> Yes | | Seizures | <input type="checkbox"/> Yes | |
| Dialysis | <input type="checkbox"/> Yes | | Sinus Problems | <input type="checkbox"/> Yes | |
| Epilepsy | <input type="checkbox"/> Yes | | Stroke | <input type="checkbox"/> Yes | |
| Dizziness/Fainting | <input type="checkbox"/> Yes | | Tobacco Use | <input type="checkbox"/> Yes | |
| Joint Replacement | <input type="checkbox"/> Yes | | Drug Use | <input type="checkbox"/> Yes | |
| Kidney Disease | <input type="checkbox"/> Yes | | Eating Disorder | <input type="checkbox"/> Yes | |
| Thyroid Disorder | <input type="checkbox"/> Yes | | Skin Rash | <input type="checkbox"/> Yes | |
| | | | Artificial Joint | <input type="checkbox"/> Yes | |

If you answered yes to any of these, please explain: _____

| | | |
|---|------------------------------|-----------------------------|
| Does your child have anything that has not been previously mentioned? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

If you answered yes, please explain: _____

SIGNATURE OF LEGAL GUARDIAN _____ DATE _____