REDFEARN Family Dental

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.
Thank you!

Today's date: _____

ABOUT YOUR CHILD

Name: _____ o Female o Male

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

School: _____ Grade: _____

Birth date: _____/_____/_____ Social security number: _____

Email for appointment reminders: _____

Fathers Name: _____

Birth Date: _____/_____/_____ Social security number: _____

Work phone: _____ Cell phone: _____

Employer: _____

Insurance Co.: _____ Group: _____

ID #: _____ Ins. Phone: _____

Mothers Name: _____

Birth Date: _____/_____/_____ Social security number: _____

Work phone: _____ Cell phone: _____

Employer: _____

Insurance Co.: _____ Group: _____

ID #: _____ Ins. Phone: _____

Who is responsible for child's account: _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Phone: _____

4185 E. Wildcat Reserve Pkwy. Ste 300, Highlands Ranch, CO 80126 Phone 303-683-2300 Fax 303-346-8014

DENTAL HISTORY

Is this your child's first dental experience? o Yes o No

What is your child's attitude toward this visit? _____

How has your child responded to past visits to the physician and/or dentist?

o no problem at all o a little nervous o very nervous o did not tolerate it at all

How would you rate <u>your</u> own anxiety (fear, nervousness) at this moment?

o high o moderately high o moderately low o low

Does your child think there is anything wrong with his or her teeth, such as a chipped tooth, decayed tooth, hurting, etc.? o Yes o No _____

How do you expect your child to behave in the dental chair?

o no problem at all o a little nervous but fine o very nervous just needs support o won't tolerate it at all

Child's favorite sport? _____Favorite Activity? _____

Is your child in good medical health? o Yes o No Is your child in good dental health? o Yes o No

MEDICAL HISTORY

When was your child's last medical exam? Date _____Year _____

Has your child required hospitalization or had a serious illness? o Yes o No

If yes, please explain: _____

Are your child's immunizations up-to-date? o Yes o No

Is your child sensitive/allergic to anything? o Yes o No

If yes, please explain: _____

Is your child presently taking any medications? o Yes o No

If yes, please explain: _____

Please check any of he following that apply to your child:

o Rheumatic fever	**o Asthma**	**o Diabetes**	**o Penicillin/Amoxicillin Allergy**
o Heart murmur	**o Hay fever**	**o Breathing disorders**	**o Mitral valve prolapse**
o Epilepsy	**o Anemia**	**o Pregnancy**	**o HIV/AIDS**
o Attention disorder	**o Latex Allergy**	**o Hepatitis**	**o Sulfa Allergy**
o Cold sores/fever blisters	**o Cancer**	**o Other _____**	

Is there any additional health information or concerns you would like us to know about?

_____

Guardian Signature _____ ***Date*** _____

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