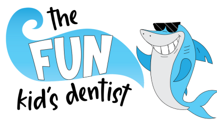
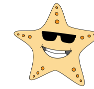


Patient Information Sheet



Date ________________

Patient's Last, First Name ____________________________________ Nickname_______________ DOB____________ Age________

Female ______ Male ______ Was patient adopted? Yes______ No______ List family siblings___________________________________

Patient's Address ____ City ____________________________ Zip _____________

Parent #1 Last, First Legal Name____ Phone # ____________________ cell or land

DOB_______________ Social Security # _________________________ Email____

Address (if different than listed above)____

Dental Ins/Address____ Phone____________________________

Group # __________________ Sub/ID#_____________________

Employer_________________________ Occupation________________________ Work #_________________ Military? Yes / No

Parent #2 Last, First Legal Name____ Phone # ____________________ cell or land

DOB______________ Social Security # _______________________ Email____

Address (if different than listed above)____

Dental Ins/Address____ Phone________________________

Group # _________________ Sub/ID#_____________________

Employer___________________________ Occupation_________________________ Work #________________ Military? Yes / No

Person financially responsible for the account?_______________________________

Dental Information

What is the purpose of this dental visit? ____

X-rays from another office? Please email to **office@thefunkidsdentist.com** Previous dentist___________________________________

How did you hear about our office? Google ______ Instagram______ Facebook_______ Tik Tok______

Chamber of Commerce______ School Presentation ______ Mom's Group______ Farmer's Market______

Friend (please name)_________________ Doctor (please name) ______________________ Other___________________________

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Patient Medical Information Pediatrician/Physician____________________________ Phone_____________________

Any history of the following:

________ ADD/ADHD
________Anemia
________Anxiety/Depression
________Asthma
________Austism
________Birth Defect-Premature/Syndrome
________Bleeding Disorder
________Cancer
________Cerebal Palsy
________Chronic Ear Infections
________Cleft Lip/Palate

________Cystic Fibrosis
________Developmentally Delayed
Age Level_________
________Diabetes
________Down Syndrome
________Eating Disorder
________Epilepsy/Seizures
________Gastroesophageal/Acid Reflux
________G-Tube Feeding
________GI Problem
________Hearing Loss/Deafness

________Heart Defect/Disease
________HIV+/AIDS
________Hydrocephaly/shunt
________Learning Disability
________Liver/Kidney Problems
________Orthopedic Pins/Rods/Plates
________Sickle Cell Disease/Trait
________Skin Problems
________Sleep Apnea/Snoring/Gagging
________Speech Delay/Impairment
________Tobacco Use
________Vision Loss/Impairment
________ NONE

Other:____

Please provide details of anything noted above____

____

Medications____

____

____

____

Allergies (drug, environmental, food) ____

____

____

Hospitalizations/Surgeries____

Parent Signature ____ **Date**_____________________