

J. Brian Putman, D.D.S. • Children's Dentistry
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GET ACQUAINTED QUESTIONNAIRE

So that we may provide your child with the best possible treatment, we ask that you complete this **confidential** patient questionnaire. Please read it carefully and **print** answers to all relevant questions.

Child's Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Birth date: _____ Age: _____ Sex: M / F Name of School: _____ Grade: _____
Names of other family members who are patients in our practice: _____

Father's Name: _____ **Social Security #:** _____
Home Address: _____ **How long?** _____
Street City: State: Zip:
Home Phone: () _____ Business Phone: () _____
Former Address: _____ **How long?** _____
Employer: _____ Occupation: _____

Mother's Name: _____ **Social Security #:** _____
Home Address: _____ **How long?** _____
Street City: State: Zip:
Home Phone: () _____ Business Phone: () _____
Former Address: _____ **How long?** _____
Employer: _____ Occupation: _____

With whom does the child reside? Father Mother Other

Person responsible for the account.

Last name: _____ First name: _____ Middle Initial: _____
Relationship: _____ Business phone: () _____
Address: _____ Home Phone: () _____
City: _____ State: _____ Zip: _____
Driver License #: _____ State: _____

Whom may we thank for referring you to our office?

Last Name: _____ First Name: _____

Dental Insurance Information:

Mother

Father

Name: _____	Name: _____
Insurance Carrier: _____	Insurance Carrier: _____
Address: _____	Address: _____
Phone: () _____	Phone: () _____
Dental Plan Name: _____	Dental Plan Name: _____
Group #: _____	Group #: _____
Social Security #: _____	Social Security #: _____
Birth date: _____	Birth date: _____

I understand that I am responsible for any charges for treatment my child receives in this office. Any balance over sixty (60) days will begin to accrue a finance charge of one (1) % per month, twelve (12) % annual percentage rate.

Parent's signature: _____ Date: _____

MEDICAL HISTORY (CHILD)

NAME: _____

BIRTH DATE: _____

Has your child any history of or difficulty with any of the following?

YES NO

- Latex Allergy
- Rheumatic Fever
- Rheumatic Heart Disease
- Cardiovascular Disease
- Heart Trouble
- Abnormal Blood Pressure
- Heart Murmur
- Congenital Heart Lesions
- Hyperactivity

YES NO

- HIV Positive
- Hepatitis
- Inflammatory Rheumatism
- Stomach Ulcers
- Kidney Trouble
- Allergies
- Hay Fever
- Sinus Trouble
- Asthma

YES NO

- Blood Disorder
- Liver Disease
- Jaundice
- Fainting Spells
- Seizures
- Diabetes
- Arthritis
- Tuberculosis
- Other _____

Was your child's birth premature? Yes No How early? _____

Has your child ever experienced excessive bleeding? Yes No

If yes, please explain: _____

Has your child ever had surgery, radiation therapy, or been hospitalized? Yes No

Purpose: _____

Does your child have any mental emotional physical limitations? _____

Is your child taking medications? Yes No If yes, what? _____

Does your child take fluoride in any form? Yes No

Has your child ever experienced an allergic reaction to any medications or substances? Yes No

If yes, what? _____

Name of Pediatrician/Physician: _____

Location or Address: _____

Does your child have any medical condition not listed above? Yes No

If yes, please explain: _____

Is this your child's first visit to any dentist? Yes No

Date of last visit: _____

Do any of the following apply to your child?

- Injury to mouth, teeth, or head
- Unhappy dental experiences
- Tooth ache
- Prolonged pacifier, thumb or finger sucking
- Mouth breather
- Ear infections
- Unusual speech habits
- Previous orthodontia
- Currently bottle fed

Does your child have any current dental complaints? Yes No

If yes, what? _____

Previous Dentist: _____

Please mention any special needs or additional information that might improve our understanding of your child.

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for the comfort and well being of my child.

Signature of Parent

or Guardian: _____

Date: _____

Doctor's

Initials: _____

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