PATIENT INFORMATION

Welcome to SOHO! We appreciate the confidence you place with us to provide dental services. To assist us in providing safe and comfortable dental care, please complete the following form. The information provided on this form is important to your dental health. If there are ever changes to this information, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: _____ Today's Date _____
Preferred Name: _____ Date of Birth _____ Age _____ [ ] Male [ ] Female
Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Who schedules appointments: _____ Parent's Marital Status: [ ] M [ ] S [ ] Sep [ ] D [ ] W
How did you hear about us? _____

Parent 1 Information:
[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other: _____
Name: _____ Preferred Name: _____
Date of Birth: _____ SSN: _____ Occupation: _____
Home Address: [ ] Same as patient's _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Email: _____ Preferred Method of Contact: _____
Is this person legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

Parent 2 Information:
[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other: _____
Name: _____ Preferred Name: _____
Date of Birth: _____ SSN: _____ Occupation: _____
Home Address: [ ] Same as patient's _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Email: _____ Preferred Method of Contact: _____
Is this person legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

In a medical emergency where neither of the above individuals can be reached, who else may we contact?
Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE INFORMATION (if applicable)

Insurance Company Name: _____ Ins. Co. Phone: _____
Group Number: _____ Policy Number: _____
Who is the primary person on this policy? _____ SSN: [ ] above _____- _____-_____
Employer of person insured: _____ DOB of insured: [ ] above _____
Do you have a secondary insurance? [ ] Yes [ ] No
Secondary Insurance Company Name: _____ Ins. Co. Phone: _____
Group Number: _____ Policy Number: _____
Who is the primary person on this policy? _____ SSN: [ ] above _____- _____-_____
Employer of person insured: _____ DOB of insured: [ ] above _____
Do you have a secondary insurance? [ ] Yes [ ] No

Signature of parent/guardian/patient Relationship to patient Date

MEDICAL HISTORY

Patient's Name: _____ **Date:** _____

1. Is the patient being treated by a physician at this time? [ ] Yes [ ] No
   If so, what is their name, specialty and phone? _____
   When was the patient's last medical check-up?_____
2. Are all immunizations current? [ ] Yes [ ] No
3. Has the patient ever been a patient in a hospital? [ ] Yes [ ] No
4. Has the patient ever received general anesthesia? [ ] Yes [ ] No
   If so, what was it for? _____
5. Is the patient allergic to anything (ex. medications / latex / foods)? [ ] Yes [ ] No
   If so, what? _____
6. Is the patient taking any medications at this time? [ ] Yes [ ] No
   If yes, what? _____

7. Has your child ever had treatment on or medical consultation for any of the following systems?

[ ] Blood / Circulatory	[ ] Gastrointestinal / Stomach	[ ] Muscles
[ ] Bones	[ ] Kidney / Bladder	[ ] Nervous System
[ ] Endocrine Glands	[ ] Heart	[ ] Nose
[ ] Ears	[ ] Liver	[ ] Skin
[ ] Eyes	[ ] Lungs	[ ] Throat / Tonsils / Adenoids

[ ] My child has NOT had any treatment or medical consultation for the above systems.

8. Has your child ever been diagnosed as having any of the following conditions?

[ ] Anemia	[ ] Emotional Disturbance	[ ] Nutritional Deficiency
[ ] Allergy	[ ] Epilepsy	[ ] Orthopedic Problems
[ ] Arthritis	[ ] Eye problems	[ ] Pneumonia
[ ] Asthma	[ ] Bleeding Problems	[ ] Premature Birth
[ ] Autism	[ ] Fainting	[ ] Respiratory Syncytial Virus
[ ] Brain Injury	[ ] Hearing Loss	[ ] Rheumatic Fever
[ ] Behavioral Problems	[ ] Heart Murmur or Condition	[ ] Scarlet Fever
[ ] Cancer	[ ] Hemophilia	[ ] Sickle Cell Anemia / Trait
[ ] Cerebral Palsy	[ ] Hepatitis	[ ] Speech Problems
[ ] Cleft Lip / Palate	[ ] HIV / AIDS	[ ] Spina Bifida
[ ] Chronic Ear Infections	[ ] Jaundice	[ ] Syndrome: _____
[ ] Convulsions / Seizures	[ ] Learning Disability	[ ] Tetanus
[ ] Diabetes	[ ] Leukemia	[ ] Other: _____

[ ] My child has NOT ever been diagnosed with any of the above conditions

9. **Is there anything else that you think we should know about your child?**_____

_____

_____

_____

_____

Signature of parent / guardian (or patient if over 18 years of age) Relationship to patient Date

DENTAL HISTORY

Child's Name:_____ Today's Date: _____

15. What is your reason for your visit today?

[ ] 1st Dental visit [ ] Establish care/ Regular check up [ ] Patient is in pain; Please describe_____

[ ] Other _____

16. Has the patient ever been to a dentist before? [ ] Yes [ ] No

17. Has the patient had any of the following treatment? If yes, please indicate how effective that treatment was in your opinion *(0 = ineffective, we were unable to complete treatment, 5= very effective, no complications/struggling)*

_____ Full Dental cleaning
_____ Deep Cleaning
_____ Fillings
_____ Nitrous Oxide/laughing gas
_____ IV sedation (in a dental office)
_____ Dental Cleaning with toothbrush
_____ Dental xrays
_____ Extractions (baby teeth/ adult teeth)
_____ Moderate/Conscious sedation
_____ General anesthesia (hospital)

18. Has the patient ever been prescribed fluoride before? [ ] Yes [ ] No

19. Does the patient have any oral habits (sucking thumb/fingers, grinding their teeth, clenching, biting cheeks/lips/tongue, self-injury) [ ] Yes [ ] No

HOMECARE

20. When are the patient's teeth brushed? *(Check all that apply)* [ ] AM [ ] PM [ ] Varies

21. Do you use floss at home? [ ] Yes [ ] No [ ] Sometimes

22. Who brushes/ flosses? [ ] Parent/ caregiver [ ] Patient [ ] Varies

23. Please describe any barriers to home care:

_____

_____

24. Are there are special precautions or treatment modifications for the safety and/or comfort of the patient?

[ ] Antibiotic pre-med
[ ] Do not recline/ Minimal reclining
[ ] No fast movements
[ ] Head phones during treatment
[ ] Several breaks
[ ] No nitrous oxide
[ ] Patient is combative
[ ] Minimize tastes
[ ] Transfer from wheelchair
[ ] Speak loudly
[ ] Patient is non-verbal
[ ] Short appointments
[ ] Patient may require sedation
[ ] Use mouth prop
[ ] Minimize liquids/water
[ ] Patient should remain in wheelchair
[ ] Patient reads lips
[ ] Minimize loud noises
[ ] Morning/Afternoon appointments only
[ ] Patient is only treated under sedation
[ ] Tell, Show, Do is effective
[ ] Other: _____

25. The patient's level of cooperation is likely to be:

[ ] Age Appropriate
[ ] Non-focused
[ ] Wiggly
[ ] Aggressive
[ ] Short Attention Span
[ ] Defiant
[ ] Playful
[ ] Combative
[ ] I don't know

26. Is there anything else you think we should know about the patient's dental history or dental needs?

_____

_____

_____