

WELCOME TO THE OFFICE OF DR. TODD J. HUGHES

Creating beautiful smiles that last a lifetime.



Child Patient Form

Date: _____

Patient's Name: _____ Nickname: _____

Birthdate: _____ Age: _____ Male Female Home phone: _____

Home Address: _____ City: _____ State: _____ Zip code: _____

Village/Subdivision: _____ Email: _____

Name of school: _____ Grade: _____

Special interest, sports or hobbies: _____

Patient's Dentist: _____ Phone #: _____

Whom can we thank for this referral? Dentist: (name) _____

Friends: (name) _____ Friends: (name) _____

Friends: (name) _____ Other: (name) _____

Family members who have been patients: (name & relationship) _____

Name of person accompanying child today: _____ Relationship: _____

SIBLINGS

Name	Date of Birth	Sex	Name	Date of Birth	Sex
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

PARENTS INFORMATION

Mother's Name: _____ Birthdate: _____

Address: (if different) _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Social Security #: _____

Employer: _____

Marital Status: Married Single Widowed Divorced Separated

Father's Name: _____ Birthdate: _____

Address: (if different) _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Social Security #: _____

Employer: _____

Marital Status: Married Single Widowed Divorced Separated

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT THAN ABOVE)

Name: _____ Birthdate: _____

Address: (if different) _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Social Security #: _____

Employer: _____

Insurance Information



Primary Dental Insurance

Secondary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Name: _____
 Insurance Co. Address: _____ Insurance Co. Address: _____
 Insurance Co. Phone: _____ Insurance Co. Phone: _____
 Group#: _____ Group#: _____
 ID# or SS#: _____ ID# or SS#: _____
 Insured's Name: _____ Insured's Name: _____
 Relationship to Patient: _____ Relationship to Patient: _____
 Insured's Birthdate: _____ Insured's Birthdate: _____
 Insured's Employer: _____ Insured's Employer: _____

MEDICAL HISTORY

Please Circle			Please Circle		
Y	N	Heart Murmur/Congenital Defect	Y	N	High Blood Pressure
Y	N	Diabetes	Y	N	Convulsions/Epilepsy
Y	N	Rheumatic Fever	Y	N	Abdominal Bleeding
Y	N	Cancer	Y	N	Hearing Impairment
Y	N	HIV +/-AIDS	Y	N	Operations/Stays in a Hospital
Y	N	Hemophilia	Y	N	Kidney/Liver Problems
Y	N	Blood Transfusions	Y	N	Handicaps/Disabilities
Y	N	Asthma	Y	N	Allergies to Drugs
Y	N	Hepatitis	Y	N	Antibiotics Prior to Dental Treatment
Y	N	Tuberculosis	Y	N	Other Medical Problems
Y	N	Heart Problems	Y	N	Medications
Y	N	Sinus Problems			

If you have circled **Yes** for any of the above, please explain: _____

DENTAL HISTORY

Y	N	Injuries to Face/Teeth	Y	N	Unfavorable Dental Experience	Y	N	Speech Problems
Y	N	Other Orthodontic Treatment	Y	N	Missing Teeth	Y	N	Mouth Breathing
Y	N	Pain/Noises in the Jaw Joint (TMJ)	Y	N	Extra Teeth	Y	N	Gums Bleed
Y	N	Root Resorption	Y	N	Finger Sucking	Y	N	Grind Teeth
Y	N	Periodontal Disease	Y	N	Tongue Thrusting			

If you have circled **Yes** for any of the above, please explain: _____

What do you see as the main problem with your teeth? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ Signature _____ Date _____

Thank you for filing this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.