Biographical and Financial Data
UT Pediatric Dentistry

BIOGRAPHICAL DATA

(Filled out by parent or guardian)

Date: _____
Patient Name: _____Nickname: _____
Sex: _____ Race: _____ Age: _____ Birth Date: _____
Pets, Hobbies: _____
Home Address: _____
Street City Zip Code
Phone: (_____) _____ Cell: (_____) _____ Pager: (_____) _____
Area Code Area Code Area code

Father's Name: _____ Birth Date: _____
Social Security Number: _____
Place of Business: _____ Phone: (_____) _____
Area Code
Business Address: _____

Mother's Name: _____ Birth Date: _____
Social Security Number: _____
Place of Business: _____ Phone: (_____) _____
Area Code
Business Address: _____

If divorced or separated, has this happened recently (6 months)? ☐ Yes ☐ No

Legal Guardian (if other than parent): _____
Place of Business: _____ Phone: (_____) _____
Area Code
Business Address: _____

Brothers/Sisters (names and ages): _____
In school or preschool? ☐ Yes ☐ No Teacher's Name: _____
Referred by: _____

IN CASE OF EMERGENCY, PLEASE COMPLETE THE FOLLOWING:
Name of nearest relative not living with you: _____
Relationship: _____
Address: _____ Phone: (_____) _____
Area Code
* Reason for seeking care: _____
_____
_____

FINANCIAL DATA

Person responsible for this account: _____
Is your child covered by: ☐ Dental Insurance ☐ Medicaid ☐ Other Social Agency
Agency or insurance company name: _____
_____
Agency or policy number: _____

If patient is covered by dental insurance, list name and address of covered employee: _____
_____

Updates:_____
_____
_____

MEDICAL HISTORY

1. Does your child have any health problems? ☐ Yes ☐ No
   If yes, explain: _____

2. Did your child have a history of health problems at birth or during initial years? ☐ Yes ☐ No
   If yes, explain: _____

3. Is your child taking any medication or drugs at this time? ☐ Yes ☐ No
   If yes, explain: _____

4. Has your child ever had any unfavorable reactions to foods, drugs, or medicines? ☐ Yes ☐ No
   Please list: _____

5. Has your child ever been hospitalized or injured? Dates: _____ ☐ Yes ☐ No
   Reason: _____

6. Does your child have any limitations to sports activities? ☐ Yes ☐ No
   If yes, explain: _____

7. Has your child had any history of the following:
   ☐ Allergies ☐ Growth Problems ☐ Blood Disorders ☐ Mental/Emotional Problems
   ☐ Diabetes ☐ Breathing Problems ☐ Seizures ☐ Pregnancy
   ☐ Heart Trouble ☐ Kidney/Liver Problems ☐ Rheumatic Fever ☐ HIV
   ☐ Use Alcohol Products ☐ Use Tobacco Products ☐ Other _____
   Comments: _____

8. Date of last medical examination: _____

9. Name of pediatrician or family physician: _____
   Address: _____ Phone: (_____) _____

10. Does your child have problems in:
    ☐ Concentrating ☐ Learning ☐ Cooperating ☐ Understanding

11. Do you think your child will be cooperative patient? _____

12. How do you discipline your child? _____
    _____

13. Is there additional medical information we should know? _____
    _____
    _____

DENTAL HISTORY

1. Is this your child's first visit to a dentist? ☐ Yes ☐ No

2. If no, give date of last examination: _____ Dentist's Name: _____

3. Has your child ever had any of the following? Please check.

   ☐ Abscess (Gum Boils) ☐ Toothaches
   ☐ Bad Breath ☐ Stained Teeth
   ☐ Cold Sores (Fever Blisters) ☐ Injury to Front Teeth
   ☐ Frequent Sore Throats ☐ Bleeding Gums

4. Does (or did) your child have/has habits which might affect oral health? If yes, check.
   ☐ Clenching or Grinding Teeth ☐ Mouth Breathing
   ☐ Finger or Thumb Habits ☐ Other _____

5. Does your child have a speech problem? ☐ Yes ☐ No

6. Does your child take fluoride? ☐ Yes ☐ No

7. When was the last time your child had dental radiographs? (X-rays) _____