LINDA A. STEELE, DDS

We make smiles shine!

Please tell us about your child

Patient name (first/middle/last)				Nickname (if any)
Birthday (M/D/Y)	Age	Sex	Grade	School
Siblings name(s) and age(s)				Pets
Hobbies/Sports/Other interests			Whom may we thank for referring you?	

Dental history

Question		
Is this your child's 1st dental appointment	Y	N
Has your child complained of dental problems or pain?	Y	N
Does your child brush daily?	Y	N
Does your child floss daily?	Y	N
Does your child take fluoride in any form?	Y	N
Does your child eat a well-balanced diet?	Y	N
Has your child had any injuries to mouth/head/teeth?	Y	N
Does your child wear a mouthguard while playing sports?		
Is their a family history of missing or extra teeth?	Y	N
Do you have orthodontic concerns?	Y	N
Is your child currently in orthodontic treatment? If yes, please list name of orthodontist.	Y	N
Has your child had any unhappy dental experiences?	Y	N

Personal and dietary history

Question		
Was your child born	❑ Pre-term	❑ Full-term
Was your child breast or bottle fed?	❑ Breast	❑ Bottle
What form of water do you drink?	❑ Tap	❑ Bottled
Does your child have any habits?	❑ Suck thumb ❑ Bite nails ❑ Use a pacifier	❑ Sleep with bottle ❑ Other

What types of beverages does your child drink on a regular basis?

What types of snacks does your child eat on a regular basis?

Medical history

Child's physician or specialist	Physician's phone number	Date of last physical exam

Question		
Is your child under the care of a physician now?	Y	N
Is your child taking any drugs or medications? *If yes, please list:*	Y	N
Has your child ever been hospitalized? *If yes, please explain:*	Y	N
Has your child every had surgery? *If yes, please explain:*	Y	N
Is your child allergic to any medications? If yes, please list.	Y	N
Is your child allergic to latex?	Y	N
Does your child have any other known allergies? If yes, please list	Y	N
Is your child current on immunizations?	Y	N

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

Condition			Condition		
Autism or special needs	Y	N	Asthma/Respiratory	Y	N
Cerebral Palsy	Y	N	Cystic Fibrosis	Y	N
ADD/ADHD	Y	N	Convulsions	Y	N
Sensory integration disorder	Y	N	Epilepsy	Y	N
Excessive bleeding	Y	N	Headaches	Y	N
Anemia	Y	N	Fainting	Y	N
Mononucleosis	Y	N	Sinus problems	Y	N
Diabetes	Y	N	AIDS/HIV	Y	N
Thyroid Disease	Y	N	Chicken Pox	Y	N
Cancer	Y	N	Measles	Y	N
Bladder	Y	N	Mumps	Y	N
Kidney	Y	N	Rheumatic Fever	Y	N
Liver	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Drugs/Alcohol abuse	Y	N

Are there any other medical concerns to discuss:

Consent for treatment

The information that I have provided is correct to the best of my knowledge. I understand it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes to my child's medical status. I authorize the dental staff to perform the necessary dental services to my child.

Signature of parent/guardian	Today's date

Child's Home Address		
Address	City, State	Zip Code

Father's (or Legal Guardian) Information		
Name	First	Last
Address (if different than child)		
Home Phone		
Work Phone		
Cell Phone		
Email Address		
Social Security Number		
Date of Birth		

Mother's (or Legal Guardian) Information		
Name	First	Last
Address (if different than child)		
Home Phone		
Work Phone		
Cell Phone		
Email Address		
Social Security Number		
Date of Birth		

Insurance Information		
Primary Subscriber/Cardholder Name		Plan Phone Number
Plan Name	Group #	Subscriber ID#
Name of Employer		

Insurance Authorization

I certify that my minor/child is covered with the stated insurance and assign directly to Dr. Linda A. Steele all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent/guardian	Today's date