PEDIATRIC DENTAL PROFESSIONALS
9015 Mountain Ridge Drive.
Houston Bldg.,Suit 320
Austin Tx 78759
(512) 346-9771

ACQUAINTANCE RECORD

DATE________________

CHILD' NAME____NICKNAME____________

HOME ADDRESS________________________CITY______________ZIP__________

PHONE NUMBER________________________AGE________BIRTHDAY____________

PERSON RESPONSIBLE FOR THE ACCOUNT________________________________

FATHER________________________________SOCIAL SECURITY #______________

DATE OF BIRTH________________________DRIVERS LICENSE #______________

EMPLOYER______________OCCUPATION______________OFFICE #______________

MOTHER________________________________SOCIAL SECURITY#______________

DATE OF BIRTH________________________DRIVERS LICENSE #______________

EMPLOYER______________OCCUPATION______________OFFICE#______________

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU________________________

HOME ADDRESS________________________CITY______________ZIP__________

HOME #________________________________OFFICE #______________________

WHO MAY WE THANK FOR REFERRING YOU_________________________________

DENTAL HISTORY	Yes	No
Is this your child's first visit to the dentist?	☐	☐
Has your child experienced any unfavorable reaction from any previous dental or medical care?(State which)_______	☐	☐
Does your child have any bad mouth habits? (thumb sucking, pacifier, etc.)____________________	☐	☐
Do you desire complete, thorough dental care for your child?	☐	☐

Last dental examination________________________
Last dental x-ray________________________
Last topical fluoride________________________
Your family dentist________________________
What particular dental problems does your child have?________________________
____
Other comments?________________________
Pediatrician (Physician)________________________
Pediatrician's Telephone #________________________
Date of last medical examination________________________

NAMES OF SIBLINGS TREATED HERE:
____
CHILD'S INTEREST:
____
FAVORITE COLOR:____________
PET'S NAME:____________

MEDICAL HISTORY	Yes	No
Has your child any history of heart trouble or a heart murmur?	☐	☐
Has your child had rheumatic fever?	☐	☐
Does your child have brain damage?	☐	☐
Does your child have seizures?	☐	☐
Does your child have any physical handicaps? If so what______ ____________________	☐	☐
Is your child allergic to any medications or foods? If so what___ ____________________	☐	☐
Does your child have prolonged bleeding from cuts?	☐	☐
Has your child any history of diabetes, kidney, or liver problems?	☐	☐
Has your child any history of asthma or breathing problems?	☐	☐

- Explain________________________
- Has your child been to the ER for a asthma attack?______
- What induces the breathing problems?______________
- Does your child use an inhaler or nebulizer?__________
- What asthma medication does your child take?__________

	Yes	No
Has your child or siblings tested positive to any of the following: __Hepatitis A(Infectious)___HepatitisB(Serum)___HIV(AIDS)	☐	☐
Previous Hospitalizations?Reason:____________________	☐	☐

Is your child taking any medications? If so what______________
____
Please describe any other medical problems (mental or physical) not mentioned above________________________

STAFF USE ONLY: System Review by doctor:______________

INSURANCE Do you have dental coverage? Yes ☐ No ☐

To avoid misunderstandings regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. Our receipts are accepted by all insurance companies when accompanied by your own insurance company's dental claim form. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is for the individual patient.

Signature____Date______________