DENTISTRY FOR CHILDREN
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Shelly K. Clark, D.D.S.
Diplomate, American Board of Pediatric Dentistry

Child's Last name First Middle

Goes by: _____ □ Male □ Female

Date of birth: _____ Age: _____

Home address

City State Zip Code

Home #

Patient resides with: □ Mother □ Father □ Both □ Guardian

□ Married □ Divorced □ Separated

If Guardian, do you have legal custody? □ YES □ NO

Is he/ she adopted? □ YES □ NO

Siblings that we see? _____

MOTHER Last name First name

Home address

City State Zip Code

SS# Date of birth

Mother's cell # Mother's work#

Email DL#

Mother's employer/ Occupation

FATHER Last name First name

Home address

City State Zip Code

SS# Date of birth

Father's cell # Father's work#

Email DL#

Father's employer/ Occupation

Whom may we think for referring you to our office?

Who is accompanying the child today? _____

Who is responsible for the patient's account? _____

Responsible Party Name

Address

City State Zip Code

Home address- Street

City State Zip Code

DENTAL INSURANCE:

Insurance Company Name_____

Address _____

Phone # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Holder's DOB _____

SS# _____

Policy Owner's Employer _____

DENTAL HISTORY:

When was your child's last dental visit? _____

What is your main concern today? _____

Has your child ever had an injury to face/teeth? □ YES □ NO

Has your child ever had a bad dental experience? □ YES □ NO

Brushing? □ Once daily □ Twice daily

Flossing? □ Once daily □ Never

Thumb? □ YES □ NO

Pacifier? □ YES □ NO

Previous orthodontic treatment? □ YES □ NO

Does your child drink well water? □ YES □ NO

Does your child wear a mouth guard for sports? □ YES □ NO