

**ROGER FLAKE, D.D.S.**

**13416 BOTHELL EVERETT HWY, SUITE 207 - MILL CREEK - WA - 98012 - (425) 338-2966**

Please answer all questions on **both** pages, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

**CHILD'S NAME** (Patient) \_\_\_\_\_ Nickname \_\_\_\_\_

(Please Circle) { Male { Female Birthdate \_\_\_\_\_ Age \_\_\_\_\_

{Stepfather {Guardian

**FATHER'S NAME** \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

( Please Circle) { Married { Single { Divorced { Separated { Widowed Email Address \_\_\_\_\_

{ Stepmother { Guardian Best Way to Contact \_\_\_\_\_

**MOTHER'S NAME** \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

(Please Circle) { Married { Single { Divorced { Separated { Widowed Email Address \_\_\_\_\_

**With whom does the child reside?** \_\_\_\_\_

**How did you hear of us:** Friend/Relative (Name) \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Drive-by \_\_\_\_\_ ValPak \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Other \_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF EACH VISIT**

PLEASE CIRCLE METHOD OF PAYMENT:

{ Cash {Check {Bankcard

**PRIMARY DENTAL INSURANCE**

Employee \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Birthdate \_\_\_\_\_  
Employee's S.S. No. \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Employee \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Birthdate \_\_\_\_\_  
Employee's S.S. No. \_\_\_\_\_

**Person responsible for child's account** \_\_\_\_\_ Phone No. \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

**IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work or Cell # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Closest Relative \_\_\_\_\_ Phone No. \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**DENTAL HISTORY**

Is this your child's first dental visit?	Yes	No	Have there been any injuries to your child's teeth or jaws...
Previous Dentist's Name? _____			Falls? Blows? Chips? Etc.? Yes No
Date of last visit: _____			Has your child ever been premedicated? Yes No
Is your child nervous about dental treatment?	Yes	No	Premedicated for dental work? Yes No
Has your child ever had a bad dental experience?	Yes	No	Does your child receive fluoride in vitamins, tablets or water?
Has your child been seen by an orthodontist?	Yes	No	Yes No

**HEALTH HISTORY**

Is your child in pain or discomfort at this time?	Yes	No	Has your child taken any medicine/drugs in the last 2 years?
Has your child been hospitalized in the past 2 years?	Yes	No	Yes No
Has your child been under the care of a medical doctor in the past 2 years?	Yes	No	Currently taking any medications? Yes No
Please list any serious medical condition(s) that your child has or has had _____			If, Yes, please list _____
Physician(s)Name(s) _____			
Address _____			Phone: _____

**Please circle any of the following which your child has now or has had in the past...**

- |                               |                                     |
|-------------------------------|-------------------------------------|
| Arthritis / Rheumatism        | Asthma                              |
| Congenital Heart Defect       | Cortisone Medicine                  |
| Heart Murmur/Rheumatic Fever  | Cough/Tuberculosis (TB)             |
| Heart Surgery                 | A.I.D.S. / H.I.V.                   |
| Chemotherapy/Cancer           | Hepatitis: A (infectious) B (serum) |
| Artificial Heart Valve        | Frequent Headaches                  |
| Diabetes                      | Pain in Jaw Joint                   |
| Blood Transfusion/Anemia      | Allergies/Hives                     |
| Sickle Cell Disease           | Hay Fever/Sinus Trouble             |
| Bruise Easily                 | Fever Blisters/Cold Sores           |
| Hemophilia                    | Fainting/Dizzy Spells               |
| Liver Disease/Yellow Jaundice | Epilepsy Seizures                   |
| Kidney Failure/Dysfunction    | Scarlet Fever                       |
| Thyroid Disease               | Shingles                            |
| Psychiatric Treatment         | Drug/Alcohol Treatment              |
| Anxiety/Depression            | X-ray / Cobalt Treatment            |

**Is your child allergic to or had an adverse reaction in the past to ...**

- |  |                   |
|--|-------------------|
| Latex  | Nitrous Oxide     |
| Local Anesthetic   | Aspirin           |
| Penicillin   | Tetracycline      |
| Erythromycin   | Other Antibiotics |
| Codeine  | Scopolamine       |
| Metals/Jewelry   |                   |
| Is your child allergic to any other medications, foods, or other substances? |                   |
| _____  |                   |
| _____  |                   |
| _____  |                   |

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. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover. **A charge of \$75.00 could be applied to your account for failed or cancelled appointments without a 48-hour notice.**

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_