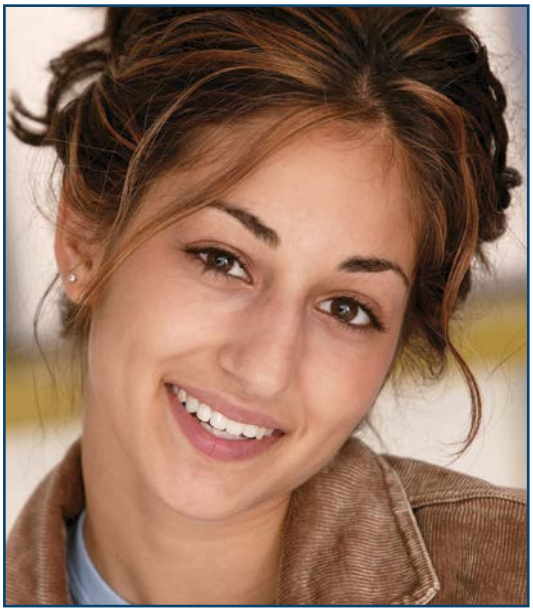
Teen Pre-Clinical History



delano dental

Today's Date: _____

ABOUT YOU

Teen's Name: _____ ❑ Female ❑ Male

Nickname: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

School: _____ Grade: _____

Birthdate: ____/____/____ Age: _____

Names/ages of brothers/sisters: _____

_____

How do you enjoy spending your free time? _____

_____

Who can we thank for referring you to our office? _____

_____

EMERGENCY INFORMATION

Person to Contact: _____

Relationship: _____ Phone: _____

❑ I give permission for Delano Dental to share my medical and account information with:

_____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Delano Dental.

Parent Signature: _____

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however, failing to attend your appointment or canceling without adequate notice more than once will result in a $50 charge. Initials: ____

707 Elm Avenue East • Delano, MN 55328 • Phone (763) 972-2800 • Fax (763) 972-9064

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DENTAL HISTORY

What was your approximate age at your first dental experience? _____

Has your dental care been regular? ❑ Yes ❑ No

Have you ever had: ❑ Orthodontic treatment? ❑ Oral surgery? ❑ Root canal treatment?

❑ clicking or popping of the jaw joint (TMJ)? ❑ Sensitivity to heat, cold, or pressure?

How do you brush your teeth? ❑ Vigorously ❑ Moderately ❑ Lightly

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Do you smoke or chew tobacco? ❑ Yes ❑ No

Are the four food groups part of your daily diet? ❑ Yes ❑ No

If not, what types of foods do you eat? _____

How would you rate your present dental health? (1=poor, 10=excellent) _____

Why? _____

Have your past experiences with dentistry been good or bad? _____

MEDICAL HISTORY

Do you feel that you are in good health? ❑ Yes ❑ No

When was your last medical exam? Date: _____ Year: _____

Have you ever required hospitalization or had a serious illness? ❑ Yes ❑ No

If yes, please explain: _____

_____

Are your immunizations up to date? ❑ Yes ❑ No

Are you sensitive/allergic to anything? ❑ Yes ❑ No

If yes, please explain: _____

Are you presently taking any medications? ❑ Yes ❑ No

If yes, please explain: _____

Please check any of the following that apply to you:

❑ Rheumatic Fever	❑ Asthma	❑ Diabetes	❑ Counseling
❑ Heart Murmur	❑ Hay Fever	❑ Breathing Disorders	❑ Mitral Valve Prolapse
❑ Epilepsy	❑ Anemia	❑ Hearing Impairment	❑ Visual Impairment
❑ Attention Disorder	❑ Other _____		

Is there any additional information that you feel would be helpful in meeting your personal needs? _____

_____

_____

Parent signature: _____

Date: _____

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