Nettleton Dental Group

946 East State St.reet
Mason City, Iowa 50401
641-424-4521

Welcome

Thank you for selecting our dental healthcare team. We strive to provide you with the best possible dental care. To help us meet all your child's dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Today's Date: (month, day, year) _____

CHILD'S INFORMATION ☐ Male ☐ Female

Child's Name: (first, m.i., last) _____ Nickname: _____

Birthdate: _____ Age: _____ Social Security #: _____

School: _____ Grade: _____

Child's Home Address: _____ City, State, Zip: _____

Phone Number: (____) _____

Emergency Contact: _____ Relationship: _____ Phone: (___)_____

PARENT'S INFORMATION ☐ Mother ☐ Stepmather ☐ Guardian

Name: _____ Home Phone: (____) _____ Work Phone (____) _____

Address: _____ City, State, Zip: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

☐ Father ☐ Stepfather ☐ Guardian

Name: _____ Home Phone: (____) _____ Work Phone (____) _____

Address: _____ City, State, Zip: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

If dental insurance, Name of company: _____ Policy #: _____

Secondary policy?: _____ Policy #: _____

If Title XIX, the child's number: _____

Any special billing requests? _____

Referred by: _____ Relationship: _____

Who is responsible for making appointments? _____

Home Phone: (____) _____ Work Phone: (____) _____ Best time to call: _____

PATIENT MEDICAL HISTORY (child - under age 14)

Patient's Name: _____

Physician: _____ Office Phone: _____ Date of last exam: _____

1. Has your child had difficulty with previous visits? ☐ Yes ☐ No

2. Has your child ever had any of the following?

Asthma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Congenital heart defect	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Physical/mental disability	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Convulsions/Epilepsy	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No
Tubes in ears	☐ Yes	☐ No	Frequent sore throats	☐ Yes	☐ No

3. Is your child taking any prescription medications? ☐ Yes ☐ No

If Yes, please list: _____

4. Is your child taking any over-the-counter medications? ☐ Yes ☐ No

If Yes, please list: _____

4. Is your child allergic to any medications? ☐ Yes ☐ No

If Yes, please list: _____

6. Female patients: Is the child pregnant? ☐ Yes ☐ No

7. Are there any other medical conditions that your child has that we should be aware of? ☐ Yes ☐ No

If Yes, please list: _____

CHILD'S HABITS

1. How often does your child brush? _____ **Floss?** _____

If under the age of 6 - Do you assist your child in brushing/flossing? _____

2. Is your child's water fluoridated? ☐ Yes ☐ No

3. Does your child take fluoride supplements? ☐ Yes ☐ No

4. Does your child:

Suck thumb/finger or use a pacifier	☐ Yes	☐ No	Chew hard objects (pencils, etc.)	☐ Yes	☐ No
Suck/bite lips	☐ Yes	☐ No	Grind teeth	☐ Yes	☐ No
Bite/chew fingernails	☐ Yes	☐ No	Clench jaws	☐ Yes	☐ No

It is important that we know about your child's dental health and medical history. Many things have a direct bearing on your child's dental health. Information you give us is strictly confidential and will not be released to anyone without your permission. Signing below also authorizes dental treatment for your child.

_____ _____

Signature of Patient (or parent of minor) (date)

CHH-0411-2

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