| Lawrence Kalke, DMD | Brian Barras, DDS, MS | John Case, DDS, MS | Toby Merriman, DMD |
1103 Rock Prairie Road Ste. 1001 ● College Station, Texas 77845 ● 979.694.5200
1704 S Blue Bell Road ● Brenham, Texas 77833 ● 979.353.0869

Date: ______________________________________

## Patient Information

Child's Name:_________________________________

Preferred Name:_______________________________

Gender (Circle): Male Female

Child's DOB:____/____/____ Age:____________

Sibling(s):____________________________________

Address:_____________________________________

City:___________________State:_______Zip:_______

Home Phone:__________________________________

Email:_______________________________________

## Parent Information

Marital Status: Single/Married/Separated/Divorced/Coupled

**Check:** ☐ **Mother** ☐ **Step Mother** ☐ **Guardian**

Name:________________________________________

Birthday:____/____/______ SSN#: _______________

Cell Phone:____________________________________

Work Phone:___________________________________

**Check:** ☐ **Father** ☐ **Step Father** ☐ **Guardian**

Name:________________________________________

Birthday:____/____/______ SSN#: _______________

Cell Phone:____________________________________

Work Phone:___________________________________

## Today's Visit

Who accompanied the child today?

Name:__________________________________

Relation: ____________________________________

Do you have legal custody of this child? Yes No

Reason for visit:_______________________________

Whom may we thank for referring you to our practice?
☐ Doctor ☐ Friend ☐ Family ☐ Yellow Pages ☐ Internet
☐ Location ☐ Advertisement ☐ Other
Name:________________________________________

Method of Payment (not including Insurance):

☐ Check ☐ Cash ☐ Credit Card ☐ Care Credit

Child's Name: ______________________________________

## MEDICAL HISTORY

**Check all that apply to your child:**

□ Abnormal Bleeding/Bruising
□ HIV/AIDS
□ Anemia
□ Asthma/Breathing Problems
□ Autism Spectrum Disorder
□ Behavior/Emotional Problems
□ Bladder/Kidney Problems
□ Cerebral Palsy
□ Chemotherapy
□ Cleft Lip and/or Palate
□ Convulsions/Seizures/Epilepsy
□ Cystic Fibrosis
□ Diabetes
□ Down syndrome
□ Ear Infections
□ Fainting
□ Hearing Problems
□ Heart Murmur
□ Heart Problems
  □ Antibiotics required (Pre-med)
□ Hepatitis
□ Hyperactivity (ADD, ADHD)
□ Immune Problems
□ Learning Disorders
□ Liver Disorders
□ Malignancy (Cancer)
□ Muscular Dystrophy
□ Radiation Therapy
□ Sickle Cell Anemia
□ Sickle Cell Trait
□ Sleep Apnea
□ Stomach Problems
□ Syndromes (please specify)
□ Thyroid Problems
□ Tuberculosis
□ Vision Problems

**□Check if none of the above apply to your child**

--Does your child have any medical history or problem(s) not listed above? Please explain.
______________________________________________________________________

--Does your child have any of the following allergies? (Check ALL that apply)
□Latex □Penicillin/Amoxicillin □Sulfa □ Nickel □Other:___________________________

**□Check if your child does not have any drug allergies**

--List all medication(s) that your child currently takes.
______________________________________________________________________

--Has your child ever been hospitalized? □ Yes □No
For what reason?____________________________________________________

--Is your child up to date on immunizations against childhood diseases? □ Yes □No

--Has your child ever had a reaction to or problem with an anesthetic? □ Yes □No

Name of Child's Physician______________________________________________________

Date of last physical examination_________________________ Results________________________________

## DENTAL HISTORY

--Is this your child's first visit to the dentist? □ Yes □No
If no, please share with us why you wish to make a change
______________________________________________________________________

--If your child has had previous dental visits, how did he/she respond?
______________________________________________________________________

--Date of last dental exam_______________ Date of last dental x-rays___________________________________

--Does your child have a previous history of any oral habits (Mouth breathing, Pacifier, Thumb sucking, Etc.)
□ Yes □No Please explain.______________________________________________________________

--Has your child had any injuries to the mouth or teeth? □ Yes □No
Please explain.____________________________________ -

--Has your child had a toothache now or recently? □ Yes □No
Please explain.____________________________________

Office use:

ASA I II III

______________________________ ___________________
Parent or Guardian Signature Date