DATE ____________

ACQUAINTANCE RECORD

HARRY M. STIMMEL, D.M.D.

DENTISTRY FOR CHILDREN AND ADOLESCENTS

We sincerely welcome you and your child into our practice. We will make your dental visits as pleasant as we can. In order for us to better understand your child, please complete this form as thoroughly as possible. Thank You!

Child's Name ____________ (FIRST) ____ (M) ____________ (LAST) Name child goes by ____________ Sex ☐ M ☐ F

Age ________ Date of Birth ____________ Weight ____________ School ____________

Child's address ____________

Name(s) of Siblings (circle those we have treated) ____________

Physician ____________ Date of last medical examination ____________

Names of Child's Favorites (pet, toy, friend, etc.) ____________

Whom may we thank for referring you to our office? (if referred by a patient, please indicate) ____________ ☐ TYN

What is your main concern for this visit? ____________

MEDICAL HISTORY

Is your child in good general health? Yes ☐ No ☐

Has your child had or does he/she have now	YES	NO
Birth Defects	☐	☐
Cleft lip or palate	☐	☐
Allergy to latex, dyes	☐	☐
Allergic reaction to medication?	☐	☐
If so, what? ____________		
Is your child taking any medication now?	☐	☐
If so, what? ____________		
Difficulty with speech	☐	☐
Hearing Loss or visual loss	☐	☐
Kidney problems	☐	☐
Asthma, respiratory, cystic fibrosis	☐	☐
Tumors, malignancies, cancer	☐	☐

	YES	NO
Learning or developmental delays	☐	☐
Autism, emotional problems	☐	☐
Mental retardation	☐	☐
Diabetes, thyroid or endocrine disorders	☐	☐
Heart disease or heart murmur requiring premedication	☐	☐
Hepatitis	☐	☐
Epilepsy or history of seizure disorder	☐	☐
Cerebral palsy, neurological or other disorders	☐	☐
Prolonged bleeding, hemophilia, anemia or blood disorders	☐	☐
Recent surgeries	☐	☐
Positive HIV test	☐	☐

DENTAL HISTORY

Is this your child's first visit to our office? Yes ☐ No ☐ Has your child been seen in any other dental office? Yes ☐ No ☐

If so, where? ____________

Date of last dental exam ____________ Last x-rays ____________

Has your child experienced any unfavorable reaction from any previous medical or dental care (state which) ____________

Does your child have any mouth habits such as finger sucking? Yes ☐ No ☐ If so, what ____________

FAMILY HISTORY

Father's Complete Name ____________ SS # ____________ DOB ____________ D.L. # ____________

Home Address ____________ City ____________ Zip ________ Phone ____________ - cell

Mother's Complete Name ____________ SS # ____________ DOB ____________ D.L. # ____________

Home Address and Phone (if different) ____________ Phone ____________ - cell

Are parents married, divorced, separated, remarried or deceased? (Please Circle ____________

Father's Place of Employment (including address & phone) ____________

Mother's Place of Employment (including address & phone) ____________

* Person to contact in case of emergency (not living at home): Name ____________

Address ____________ Phone ____________

DENTAL INSURANCE

Dental Ins. Co. ____________ I.D. # ____________ Group # ____________

Address ____________ Phone ____________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

Parent Signature ____________

CONSENT FOR TREATMENT OF A MINOR

The undersigned hereby authorizes Dr. Stimmel to perform the examination and after explanation, the necessary dental services, including radiographs, and those methods deemed appropriate for the care of the above-named child. This consent shall remain in full force until cancelled by either party.

Parent Signature ____________