John M. Collier, DDS
J. David Collier, DDS
Pediatric, Adolescent &
Special Needs Dentistry

St. Cloud - Buffalo - Baxter
(320) 253-8380 • (866) DDS-GUYS

Today's Date_______________

PATIENT HISTORY

Child's Name ________________________________ M____ F____ SS# ____________________________ Birthdate______________ Age_____
FIRST MI LAST

Father's Name ________________________________
FIRST MI LAST

Married Y____ N____

Employer____________________________________

Position ____________________________

Work Phone___________________________

Home Phone __________________________

Cell Phone ___________________________

Home Address ____

City, State, Zip____

____

Mother's Name ________________________________
FIRST MI LAST

Married Y____ N____

Employer____________________________________

Position ____________________________

Work Phone___________________________

Home Phone __________________________

Cell Phone ___________________________

Home Address ____

City, State, Zip____

____

IN CASE OF EMERGENCY - NAME, ADDRESS, PHONE # OF CLOSEST RELATIVE NOT IN RESIDENCE WITH YOU

____

# of Brothers ______ Sisters ______ Child's favorite hobby ____________________ Sport __________________ Any pets?___________________

Whom may we thank for referring you to our office? ____

DENTAL INSURANCE INFORMATION

Father/Guardian's Name ______________________________________

Employer_____________________________ Group # ______________

ID # ______________ Birthdate____________ Ins. Co. ______________

SS#_____________________________ Relationship to patient________

Mother/Guardian's Name ______________________________________

Employer_____________________________ Group # ______________

ID # ______________ Birthdate____________ Ins. Co. ______________

SS#_____________________________ Relationship to patient ________

Is child eligible for treatment under Medical Assistance or MN Care?____No ____Yes-Child's MA or MN Care ID#___________________County_________

DENTAL HISTORY

Date of last dental visit______________________________

For what service?_____________________________________

__________________________ By Dr. _______________

Any previous unhappy dental / medical visits? ____Yes ____No

Has your child complained of any dental problems? ________

____

Any injuries to mouth, teeth, head? ____________________

____

Any mouth habits: nail biting, mouthbreathing, etc.?

____

____

Any lost teeth? ________________________________

	YES	NO
Does your child brush daily?	☐	☐
Do you assist child with brushing?	☐	☐
How often?____________________		
Is dental floss used?	☐	☐

How does your child receive fluoride?

___Water supply ___ Toothpaste ___Vitamins

___Dentist ___Tablets ___None _______Other

Child's attitude to dentistry______________________________

____

____

____

____

MEDICAL HISTORY

Physician_______________________________ Address____ Phone_______________________

Date of last physical exam__________________________________ Results__________________________ Height_________ Weight________

(OVER, PLEASE)

MEDICAL HISTORY

MEDICAL HISTORY	YES	NO	Explain
Is your child in good health?	❑	❑	______
Is he/she presently under care of physician?	❑	❑	______
Is he/she taking any medications?	❑	❑	______
Has your child ever been hospitalized?	❑	❑	______
Has he/she ever had surgery?	❑	❑	______
Are your child's immunizations current?	❑	❑	______

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH CONDITIONS? (If so, please check)

	YES	NO
1. Rheumatic fever or rheumatic heart disease	❑	❑
2. Congenital heart disease or heart murmur	❑	❑
3. Allergies A) Food, Dust, etc.	❑	❑
B) Drug, i.e. penicillin, etc.	❑	❑
C) Rubber, Latex	❑	❑
D) Unknown__________________	❑	❑
4. Asthma or hay fever	❑	❑
5. Arthritis or rheumatism (painful swollen joints)	❑	❑
6. Diabetes or blood sugar problems	❑	❑
7. Blood, Blood Products, Transfusion	❑	❑
8. Any prolonged bleeding, bruises easily or frequent nose bleeds	❑	❑
9. Anemia / Blood Disorder / Sickle Cell Disease	❑	❑
10. HIV / AIDS	❑	❑

	YES	NO
11. Tuberculosis(TB) or pneumonia	❑	❑
12. Kidney or bladder problems	❑	❑
13. Liver problems, jaundice or hepatitis A, B, or C	❑	❑
14. Glandular or hormonal problems	❑	❑
15. Pregnant or Possibly Pregnant	❑	❑
16. Accidents or severe infections	❑	❑
17. Convulsion, seizures, fainting or epilepsy	❑	❑
18. High / Low blood pressure	❑	❑
19. Speech, learning or hearing disorders	❑	❑
20. ADD / ADHD	❑	❑
21. Autism	❑	❑
22. Childhood illnesses	❑	❑
23. Other (please explain)______________________		

If yes to any of the above, please explain ____

____

Method of infant feeding______________________ Eating habits (briefly explain)______________________

____

Are there any psychological or emotional/behavioral problems you would like to bring to our attention? ______________________

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have NOT discussed ____

____

I hereby certify the foregoing information is correct and true. Because my child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be done by Dr. Collier. Additionally, I understand that I may be asked to allow a K.O.A.L.A. Dental Care staff member to escort my child through the dental experience while I wait in the lobby. Authorization is hereby granted as such. Furthermore, I will be responsible for any bill incurred on my child for dental services.

Signed______________________________ **Date**______________________

SUMMARY (For Doctor's Use)

HISTORY TAKEN FROM:

______________________________(Relationship) Recorded by: __________________DATE __________________

______________________________(Relationship) Recorded by: __________________DATE __________________

______________________________(Relationship) Recorded by: __________________DATE __________________

______________________________(Relationship) Recorded by: __________________DATE __________________