John M. Collier, DDS
J. David Collier, DDS
Aruna Rao, DDS
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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____ Birthdate_____ Age_____
FIRST MI LAST

Father/Guardian's Name _____ Mother/Guardian's Name _____
FIRST MI LAST FIRST MI LAST

Relationship to Patient ☐Father ☐Stepfather ☐Guardian ☐Other

Relationship to Patient ☐Mother ☐Stepmother ☐Guardian ☐Other

Married Y____ N____ Birth Date ____ /____ /____

Married Y____ N____ Birth Date ____ /____ /____

Employer _____

Employer _____

Position _____

Position _____

Work Phone_____

Work Phone_____

Home Phone _____

Home Phone _____

Cell Phone _____

Cell Phone _____

Home Address _____

Home Address _____

City, State, Zip _____

City, State, Zip _____

_____

_____

Email Address _____

Email Address _____

Who is accompanying the child today? _____

EMERGENCY CONTACT (other than parent or guardian) Name_____ Phone _____

How did you hear about us? Dentist/Office _____ Physician _____ Other _____

DENTAL INSURANCE INFORMATION

Father/Guardian's Name _____ Mother/Guardian's Name _____

Employer_____ Employer_____

Position _____ Position_____

Ins. Co. _____ Group #_____ Ins. Co. _____ Group #_____

ID#_____ Birthdate_____ SS # _____ ID#_____ Birthdate_____ SS # _____

Relationship to Patient _____ Relationship to Patient _____

Is child eligible for treatment under Medical Assistance or MN Care? No ___ Yes ___ Child's MA or MN Care ID#_____

MEDICAL INSURANCE INFORMATION

Name of insurance company_____

DENTAL HISTORY

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

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? _____

How does your child receive fluoride?

___Water supply ___ Toothpaste ___Vitamins

___Dentist ___Tablets ___None _____Other

Child's attitude to dentistry_____

_____

_____

_____

_____

(OVER, PLEASE)

MEDICAL HISTORY

Physician_____ Address_____ Phone_____

Date of last physical exam_____ Results_____ Height_____ Weight_____

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		YES	NO
1. Rheumatic fever or rheumatic heart disease	❑	❑	11. Tuberculosis(TB) or pneumonia	❑	❑
2. Congenital heart disease or heart murmur	❑	❑	12. Kidney or bladder problems	❑	❑
3. Allergies A) Food, Dust, etc.	❑	❑	13. Liver problems, jaundice or hepatitis A, B, or C	❑	❑
B) Drug, i.e. penicillin, etc.	❑	❑	14. Glandular or hormonal problems	❑	❑
C) Rubber, Latex	❑	❑	15. Pregnant or Possibly Pregnant	❑	❑
D) Unknown_____	❑	❑	16. Accidents or severe infections	❑	❑
4. Asthma or hay fever	❑	❑	17. Convulsion, seizures, fainting or epilepsy	❑	❑
5. Arthritis or rheumatism (painful swollen joints)	❑	❑	18. High / Low blood pressure	❑	❑
6. Diabetes or blood sugar problems	❑	❑	19. Speech, learning or hearing disorders	❑	❑
7. Blood, Blood Products, Transfusion	❑	❑	20. ADD / ADHD	❑	❑
8. Any prolonged bleeding, bruises easily or frequent nose bleeds	❑	❑	21. Autism	❑	❑
9. Anemia / Blood Disorder / Sickle Cell Disease	❑	❑	22. Childhood illnesses	❑	❑
10. HIV / AIDS	❑	❑	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. John Collier, Dr. David Collier, Dr. Aruna Rao and / or Dr. Emma Zimmerman. 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. In accordance with Federal regulations: Finance charges of 0.67% per month (8% APR) occur on balances over 30 days.

Parent/Guardian (please print) _____ **Parent/Guardian Signature** _____ **Date** _____

SUMMARY (For Doctor's Use)

HISTORY TAKEN FROM:

_____(Relationship) Recorded by:_____Date _____