HEIDI BRANDENBURG
DDS

3948 West 50th Street | Suite 201 | Edina, MN 55424 | 952 922 8787 | hb-dds.com

Patient Information / Minor

The following confidential information is important for the dentist to know planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name	Date of Birth
Address	Cell Phone #
City, State, Zip	Home Phone #
Email Address	Preferred Contact Method
Name of person to contact in case of emergency	Phone #
How did you find out about our dental office?	

Account Information

Person Responsible for Account (address, if different from above)		Social Security #
Employer	Position	Work Phone #
If you will be using Dental Insurance, please provide the following:		
Dental Insurance Company		Group #
Subscriber Name		Subscriber Date of Birth
Subscriber Employer		Subscriber ID#

Health Information—Dental

Previous Dentist		**Do any of the following apply to your child now or in the past?**					
Address		Toothache	Yes	No	Mouth sores	Yes	No
Child's Last Dental Exam	Child's Last Dental X-rays	Cold sensitivity	Yes	No	Swelling in the mouth	Yes	No
Reason for this visit		Heat sensitivity	Yes	No	Tobacco user	Yes	No
What do you feel is the present condition of your child's mouth?		Pressure sensitivity	Yes	No	Grinding/Clenching	Yes	No
Are you interested in ongoing dental care for your child?		Sweet sensitivity	Yes	No	Jaw joint noise	Yes	No
How often does your child brush their teeth?		Bleeding gums	Yes	No	Locked jaw	Yes	No
What type of toothbrush does your child currently use? Manual? Electric?		Sensitive gums	Yes	No	Improper bite	Yes	No
How often does your child floss their teeth?		Unattractive teeth	Yes	No	Braces	Yes	No
What concerns do you have about your child's smile? Teeth?		Other? Please explain:					

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Health Information—Medical

Patient Name

Physician's Name	Is your child allergic to:					
Address	Penicillin	Yes	No	Local Anesthetic	Yes	No
Phone	Codeine	Yes	No	Latex/Other	Yes	No

Is your child currently under the care of a physician? If yes, explain.

Has your child ever had a serious illness or accident? If yes, explain.

List all medications or drugs (and dosages) your child is taking:

Do any of the following apply to your child now or in the past?

Heart Disease	Yes	No	Thyroid Problem	Yes	No	Tuberculosis/Lung Disease	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Jaundice	Yes	No	Asthma/ Hay Fever	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Hepatitis	Yes	No	Sinus Problems	Yes	No	Frequent Ear Infections	Yes	No
Congenital Heart Defect	Yes	No	Ulcers / Reflux	Yes	No	Epilepsy/ Seizure	Yes	No	How often?		
Abnormal Blood Pressure	Yes	No	Intestinal Issues	Yes	No	Fainting Spells	Yes	No			
Abnormal Bleeding	Yes	No	Excessive Thirst/ Urination	Yes	No	Chemical Dependency	Yes	No			
Diabetes	Yes	No	Anemia	Yes	No	Mental Health Care	Yes	No			

Any additional information? Please explain:

The information is correct to the best of my knowledge. I authorize diagnostic and therapeutic procedures, and the administration of such medications as may be necessary for proper dental care of my minor child/guardian.

Parent or Guardian Signature	Date
D.D.S. Signature	Date