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Welcome to our office. Please complete this confidential form as accurately as possible so that we can provide the best dental care for your child. As a matter of course, we will notify your child's physician that we are responsible for your child's dental care.

GENERAL INFORMATION

Today's Date ____/____/____

Patient's Full Name _____
Address (incl. City, St., Zip) _____
Home Telephone Number _____
Parent's Name _____ Home Telephone _____
Parent Employed By _____ Bus. Telephone _____
Parent's Name _____ Home Telephone _____
Parent Employed By _____ Bus Telephone _____

Name and Address of person responsible for child's account, if other than above _____

Whom May We Thank For Referring You to Us? _____
If it is a parent, do you know the name of the child? _____
Their Telephone Number and Address _____

Reason for Seeking Dental Care _____

CHILD'S HISTORY

Age _____ Date of Birth ____/____/____ Sex: M F
Favorite Sport, TV Program, Activity or Hobby _____
Any other pertinent historical information about your child _____

MEDICAL HISTORY

Child's Physician and Address _____
Date of last physical examination and results _____
Is your child under medical care at the present time and if so, for what? _____

Is your child taking any medications and if so, what? _____
Is your child ALLERGIC to any medicine, food or substance? _____
Has your child ever been hospitalized and for what? _____
Was pregnancy and delivery normal? _____
Significant Paternal/Maternal History _____
Does your child bleed or bruise easily or excessively? _____

OVER

MEDICAL HISTORY (cont.)

Please check if your child has or had any history or difficulty with any of the following:

_Asthma
_Behavior
_Blood Disorders
_Brain Injury
_Cancer
_Cerebral Palsy
_Congenital Birth Defects
_Cong. Heart Disease
_Diabetes
_Ears
_Eyes
_Emotional Problems
_Endocrine
_Epilepsy
_Headaches
_Heart, i.e. Murmur
_Hepatitis
_Infections (Viral/Bacterial)
_Jaundice
_Kidney
_Learning
_Liver/GI
_Lung
_Mental Retardation
_Rheumatic Fever
_Seizures
_Sickle Cell Disease
_Skin
_Speech
_Thyroid
_Transfusions
_Tuberculosis
_Other

Please describe the items which you checked _____

_____

DENTAL HISTORY

Does the mother/primary care provider have a high cavity history? Y N
Is this your child's first visit to the dentist? _____
If not, last visit and reason for that visit ? _____
Has your child ever had any dental x-rays? _____
Has your child had any injury to the teeth, mouth, jaw or head? _____
Does an adult assist your child with toothbrushing? _____
Has your child had any unhappy or unpleasant dental experience? _____
Has your child ever had any orthodontic treatment and if so, who performed the treatment? _____

_____

Has your child had a history of the following and if so, when:

_Pacifier
_Mouthbreathing
_Teeth grinding
_Nail biting
_Bedtime bottle
_Breast Feeding
_Fluoride Supplements
_Non-fluoridated Water
_Bottled Water
_Filtered Water
_Thumb Sucking
_Finger Sucking

Please list any questions, concerns or comments you may have _____

_____

Because your child is a minor, it becomes necessary that signed permission is obtained from the parent or guardian before any and/or all necessary dental services and methods can be rendered. Accordingly, please read the following statement carefully and sign below:

I understand that the information I provide on this form and update forms is essential to determine my child's dental needs and the provision of dental treatment. I understand that if any changes occur in my child's health, I am to report it to this office as soon as possible. I have read, understand each question, and have answered all of them truthfully and to the best of my ability. I have discussed my child's health history with the doctor. Furthermore, the undersigned will be responsible for any fees incurred on the above child for dental treatment rendered.

Parent or Guardian's Signature _____ Date

(Relationship, if not parent)