

Demographic Information

Patient _____ Today's Date _____

Name child would like to be called _____ Home Phone _____

Birthday _____ Age _____ Sex _____ Cell Phone _____

Guardian's Email _____

Home Address _____

street

town

state

zip code

Names and ages of other children in family _____

School _____ Grade _____

Guardian 1: _____ Relation to patient _____

Employer _____ Phone _____

Guardian 2: _____ Relation to patient _____

Employer _____ Phone _____

Who has legal custody of patient? _____ Dental Insurance: Yes No

Person responsible for payment of account _____ SS# _____ DOB _____

Name of child's physician/group _____ City/St _____ Ph # _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

Health History

Yes No Is your child in good health? Date of last physical exam _____

Yes No Has your child ever had a health problem? _____

Yes No Has your child ever been hospitalized? Please give reason and dates _____

Yes No Is your child allergic to anything? _____

Yes No Is your child currently taking any medications? Please give medication, dose and reason _____

Yes No Were there any problems at birth? _____

Please circle if your child has been treated for any of the following:

Heart disease

Bleeding/transfusions

Asthma/breathing

Blood dyscrasias

Liver/GI disease

Anemia

Diabetes

AIDS

Kidney disease

Rheumatic fever

Hepatitis

Mental delays

Speech/hearing

Seizures

Cleft lip/palate

Physical delays

Eyesight

Congenital birth defects

Personality/social

Other problems

Cancer/tumors

Recurrent headaches

Frequent infections

Adverse Drug reations

Cerebral palsy

Sianificant iniuries

Endocrine/arowth

Autism

Please elaborate on any items circled: _____



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- Do you consider your child to be advanced in the learning process
 progressing normally
 slow in the learning process
- Was your child breast fed bottle fed at what age was it stopped? _____

Dental History

- Yes No Has your child ever been to the dentist? Date of last xrays (if taken) _____
 Name of dentist and date _____
- Yes No Has your child experienced any unfavorable reaction from previous dental care? Explain _____
- Yes No Does your child suck a finger, thumb or pacifier?
- Yes No Does your child have pain with chewing, yawning, or wide opening?
- Yes No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

- Cavities Toothache Teeth Sensitive
 Trauma Gum Infections Color of teeth
 Orthodontics Jaw Sounds Other

Comments: _____

Fluoride History

- Yes No Is your home water supply fluoridated?
- Yes No Does your child use a fluoride toothpaste?
- Yes No Do you give your child any other form of fluoride? What? _____
- Yes No Does your child participate in a school fluoride rinse program?

Office Use Only
<input type="checkbox"/> Fl- City Water
<input type="checkbox"/> Pvt. Well
<input type="checkbox"/> Public Well _____ppm
<input type="checkbox"/> H ₂ O test kit given

Consent for Dental Treatment

I request and authorize Dr. Taylor to examine, clean, and provide dental treatment on my child's teeth. This treatment may include sealants, restorations(fillings) or crowns if necessary. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Taylor to diagnose and/or treat my child's dental problem(s). I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Taylor will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ Date _____