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### Child's Dental Information

Reason for today's visit:  Exam  Emergency  Consultation

Is Child in pain?  No  Yes How Long? \_\_\_\_\_

Please indicate  any of the following problems:

Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth

Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw

Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath

Blisters/Sores in or around the mouth.  Broken/Chipped tooth  Loose tooth

Other(s): \_\_\_\_\_

Does child require pre-medication?  Yes  No  Don't know

Previous Dentist: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Last Dental exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Dental X-rays: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Times a day child brushes? \_\_\_\_\_ Times a week child flosses? \_\_\_\_\_

Is the child's water fluoridated?  Yes  No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

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### Child's Medical History

Is Child taking any of the following medications?  Pain killers (INCLUDING ASPIRIN)  Ritalin  Stimulants

Blood Thinners  Tranquilizers  Insulin  Muscle relaxers  Others: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
DOCTOR'S NAME OR CLINIC NAME PHONE#

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Does Child have or ever had any of the following diseases, medical conditions or procedures?**

<b>Y N</b> Heart Murmur	<b>Y N</b> Tonsillitis	<b>Y N</b> High/Low Blood Pressure
<b>Y N</b> Rheumatic fever	<b>Y N</b> Respiratory Problems	<b>Y N</b> Hepatitis
<b>Y N</b> Artificial Heart Valves	<b>Y N</b> Asthma/Difficulty Breathing	<b>Y N</b> Artificial Bones/Joints/Implants
<b>Y N</b> Congenital Heart defect	<b>Y N</b> Blood Transfusion(s)	<b>Y N</b> Liver/Kidney/Organ Problems
<b>Y N</b> Scarlet Fever	<b>Y N</b> Leukemia/Anemia	<b>Y N</b> HIV+/AIDS/ARC
<b>Y N</b> Surgeries/Operations	<b>Y N</b> Diabetes/Hypoglycemia	<b>Y N</b> Tuberculosis TB
<b>Y N</b> Cancer/Tumors	<b>Y N</b> Hemophilia	<b>Y N</b> Psychiatric Problems
<b>Y N</b> Chemotherapy	<b>Y N</b> Abnormal Bleeding	<b>Y N</b> Hyper Active/ADD
<b>Y N</b> Jaw Problems TMJ/TMD	<b>Y N</b> Cleft Lip/Palate	<b>Y N</b> Fainting/Seizures/Epilepsy
<b>Y N</b> Hearing Problems	<b>Y N</b> Birth Defects	<b>Y N</b> Cerebral Palsy

Please list any other medical condition(s) child has or ever had: \_\_\_\_\_

Is Child allergic to:  Latex  Penicillin/Amoxicillin  Tetracycline  Dental Anesthetics (Novocaine)

Aspirin  Food allergies  Other(s): \_\_\_\_\_

Please rate the child's general health from 1-10: \_\_\_\_\_ Does child wear contact lenses?  Yes  No

Has this child ever taken the drug Ritalin?  No  Yes/How long? \_\_\_\_\_ Child's Blood type: \_\_\_\_\_

Does this child do any of the following?  Thumb/Finger Sucking  Tongue Thrusting/Sucking

Heavy Snoring  Mouth Breathing  Lip Sucking/Biting

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent or Guardian  Other:

**UPDATE (OFFICE USE)**

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

Comments \_\_\_\_\_

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

Comments \_\_\_\_\_

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

Comments \_\_\_\_\_