CHILD'S INFORMATION AND HEALTH HISTORY

DATE_____

INITIAL EXAM

CHILD'S NAME_____ (NICKNAME IF ANY) DATE OF BIRTH_____

CHILD'S ADDRESS_____ CHILD'S PHONE_____

HOBBIES, SPORTS AND INTEREST_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RESIDENCE ADDRESS_____

RESIDENCE PHONE_____ WORK PHONE_____ CELL PHONE_____

DENTAL INSURANCE (if applicable)_____

EMPLOYED BY_____ ID#_____

BUSINESS ADDRESS_____

DENTAL HISTORY

CHIEF ORAL COMPAINT_____

LAST DENTAL EXAM (date)_____ ANY UNFAVORABLE DENTAL EXPERIENCES ❑Y ❑N

If YES, please explain_____

Does your child have or use any of the follow? Indicate with a (✓)

- ❑ Traumatic Injury to mouth or teeth
- ❑ Teeth sensitive to heat, cold,
- ❑ Bleeding gums. How long? _____
- ❑ Food impaction
- ❑ Clenching or grinding of teeth
- ❑ Swelling or lumps in mouth
- ❑ Frequent blisters on lips or mouth
- ❑ Pain around ear
- ❑ Bad breath
- ❑ Complications from extractions
- ❑ Topical Fluoride Treatment
- ❑ Orthodontic treatment
- ❑ Mouth breathing
- ❑ Oral habits; thumbsucking, finger-nail biting, etc.
- ❑ Texture of toothbrush _____
- ❑ Frequency of brushing _____
- ❑ Dental Floss
- ❑ Disclosing tablets or solutions
- ❑ Fluoride supplements
- ❑ Between meal snacks
- ❑ Well balanced diet

MEDICAL HISTORY

PHYSICIAN'S NAME_____ DATE OF LAST EXAM_____

Does your child have or use any of the follow? Indicate with a (✓)

- ❑ Allergy to Penicillin
- ❑ Allergies to other drugs
- ❑ Allergies to anesthetics
- ❑ Any heart ailments
- ❑ Radiation treatment
- ❑ Excessive bleeding from cut/extraction
- ❑ Anemia or blood problems
- ❑ Asthma
- ❑ Hay fever or general allergies
- ❑ Diabetes
- ❑ Kidney problems
- ❑ Liver problems/hepatitis
- ❑ Malignancies/leukemia
- ❑ Psychiatric care/emotional problems
- ❑ Rheumatic Fever
- ❑ Immune System Disorder (AIDS, HIV, ARC)
- ❑ Sinus problems
- ❑ Physical or mental handicap
- ❑ Thyroid disorder
- ❑ Eye disorder
- ❑ Tonsillitis
- ❑ Ulcer or colitis
- ❑ Extreme nervousness or apprehension
- ❑ Other (any current medical treatments including drugs taken, even though not listed above) _____

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APPOINTMENTS: We may charge a $25 fee for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, heat, electric, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved especially for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and they are personally responsible for payment fees. We will prepare forms or reports to help the person responsible obtain benefits from the insurance company, upon receipt of full (or partial payment) of the bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual treatment provided.

SIGNATURE_____ DATE _____