5 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**

6 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#

_____ Last Medical Exam: ____/____/____
ADDRESS CITY STATE ZIP

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

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