Amy K. DeYoung, D.D.S., M.S., P.C. **Pediatric Dentistry**
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Patient Information

Patient_____ Date_____
Name child would like to be called_____
Birthday_____ Age_____ Sex_____ Home Phone_____
Home Address_____
street *town* *zip code*
Your name_____ Relationship to child_____
Other children in family previously seen in our office_____
School_____ Grade_____
Mother_____ Date of Birth_____
Mother's Employer_____ Phone_____
Father_____ Date of Birth_____
Father's Employer_____ Phone_____
Who has legal custody of patient?_____
Person responsible for making appointments_____
Emergency contact (name/phone, other than self and/or spouse _____
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? Name of child's physician _____
Date of last physical exam_____
☐ Yes ☐ No Has your child ever had a health problem?_____
☐ Yes ☐ No Has your child ever been hospitalized or had any significant injuries? 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 check if your child has been treated for any of the following:

☐ Heart disease/murmur ☐ Abnormal Bleeding ☐ Transfusions & Dates_____
☐ Liver/GI disease ☐ Diabetes ☐ AIDS ☐ Asthma
☐ Kidney disease ☐ Rheumatic fever ☐ Hepatitis ☐ Mental delays
☐ Speech/hearing ☐ Seizures ☐ Cleft lip/palate ☐ Physical delays
☐ Sight ☐ Congenital birth defects ☐ Personality/social ☐ Cerebral palsy
☐ Cancer/tumors ☐ Recurrent headaches ☐ Frequent infections ☐ Other problems
☐ Anemia ☐ Blood dysrasias ☐ Autism

Please explain any items checked:_____
_____
_____

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?_____
Does your child use a sippy-cup? _____ How Often?_____
What beverage does your child usually drink? _____

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? 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

Office Use Only
- ☐ Fl- City Water
- ☐ Pvt. Well
- ☐ Public Well _____ppm
- ☐ H_2O test kit given

☐ 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?

Consent for Dental Treatment

(MUST be signed by parent or legal guardian)

I request and authorize Dr. DeYoung to examine and clean my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. DeYoung to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. 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. DeYoung 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 and/or fees incurred on the account.

Signature _____ **Date** _____

Provider Initials _____