

Patient Information

Patient _____ Date _____

Name child would like to be called _____

Birthday _____ Age _____ Sex _____

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 _____

Home Address (if different than child's) _____

Mother's Employer _____ Work Phone () _____

Home Phone () _____ Cell Phone () _____

Father _____ Date of Birth _____

Home Address (if different than child's) _____

Father's Employer _____ Work Phone () _____

Home Phone () _____ Cell 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? _____

Yes No Is your child up to date on all vaccinations? _____

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

- 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?

<small>Office Use Only</small>
<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 (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 _____