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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#

Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

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

Comments \_\_\_\_\_

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

Comments \_\_\_\_\_

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

Comments \_\_\_\_\_