Child's Name: Today's Date:
Primary Address: Postal Code:
Mother's Name: Cell: Email Address:
Father's Name: Cell: Email Address:
Phone HM:
Date of Birth: Age: Gender: M F
Emergency Contact: Phone#:

Physician: ________________ Phone: ______________ Previous Dentist: _____________ Phone#: ____________

Medical History

Has your child seen a doctor in the past year? If yes, why? ____
Does your child have any drug allergies that you are aware of? Yes/No If yes, please list:

____
Does your child have a Latex allergy? Yes/No
Is your child presently taking any medication? Yes/No If yes, please list: ______________________________________
Has your child ever taken Penicillin Yes/No
Has your child ever been hospitalized? Yes/No If yes, or what reason? ______________________________________
Has a dentist, physician or specialist ever recommended taking antibiotics prior to dental treatment or surgery? Yes No
Does your child have diabetes or require special care due to a medical condition? Yes/No If yes, please explain:____

Please circle any of the following conditions that apply to you, past or present

Heart Ailment or Murmur | Heart Surgery | Arthritis
Cancer | Asthma | Respiratory Disease
Chronic Allergies | Sinus Problems | Nervous Problems
ADD/ADHD | Kidney Problems | Liver Problem
Hepatitis | Any Blood Disease | Epilepsy
Stomach or Intestinal Problems

Are there any conditions not listed that we should be aware of? ____

Dental History

When was their last complete dental exam? __________________ Were x-rays taken? Yes/No
Has your child ever had Freezing? Yes/No Were there any complications? Yes/No If yes, explain: __________________
Do you feel your child's daily dental care is adequate? Yes/No
How many times per week do you supervise or assist with your child's brushing? ________________________________
Does your child suck his/her thumbs, fingers or pacifier? Yes/No
How comfortable would you say your child is with today's visit? (1-10) 1-apprehensive 10- Excited: _________________
Do you have concerns with your child's teeth? ____
Is your child experiencing any discomfort or pain in their mouth/teeth? ____
Do you have any concerns not covered on this form? ____

Permission to Treat, Release of Information & Privacy

This is to certify that I, the undersigned, as parent or guardian of the above mentioned child, consent to the performance of any dental and oral surgery procedures agreed to be necessary or advisable. Including the use of local anesthetic as needed. I will assume full responsibility for fees associated with these procedures. I authorize the release to my insurance company and/or plan administrator any information contained in manual or electronic claims.

Patient's Signature: _________________________________ Date: __________________________