

Patient Name _____ Likes to be called _____ Patient Address _____

City _____ State _____ Zip _____ Home Phone: _____ Sex _____ Birthdate (Patient) _____

Patient's SS# _____ Pediatrician _____ Referred by _____ Today's Date _____

Mother's Information

Father's Information

Parent's Information

Name _____ Name _____ Single _____

Occupation _____ Occupation _____ Married _____

Employer _____ Employer _____ Divorced _____

Business Phone _____ Business Phone _____ Spouse Deceased _____

Social Security _____ Social Security _____ Separated _____

Birthdate _____ Birthdate _____

Patient's weight _____ lbs _____ kgs

Reason for dental visit _____

MEDICAL HISTORY

Has your child ever had any of the following? (Please check YES or NO by each item)

If YES please explain below:

YES NO

	1. Heart Disease
	2. Rheumatic Fever
	3. Hepatitis or Liver Disease
	4. Diabetes
	5. Blood Transfusion
	6. Abnormal Bleeding
	7. Epilepsy
	8. Tuberculosis
	9. Arthritis
	10. Kidney Disease
	11. Thyroid Disease
	12. Hormonal dysfunction
	13. Allergies to drugs or medications
	14. Hay Fever
	15. Asthma
	16. Tumor
	17. Mumps
	18. Measles
	19. Chicken Pox
	20. Pneumonia
	21. Constant Ear Infections
	22. Anemia
	23. AIDS or AIDS related complex
Explain: Number, date, and duration _____	
Additions: Date _____	

	YES	NO
Is this your child's first visit?		
Is your child in good health?		
Does your child have a mental or physical handicap? Explain		
Did your child have a baby bottle at nap and/or bed time? How long?		
Does your child have a finger habit?		
Has your child had an unfavorable reaction to medical/dental treatment?		
Is your child taking any drugs or medicine now? What?		
Does your child have any other medical problem we should know about?		

CONSENT

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any and/or all dental treatment can be started and completed by the doctor. Our examination may or may not include dental x-rays, depending on your child's specific needs. Photographs for diagnosis, treatment planning and teaching may be made.

Consent is hereby given for restorative and/or surgical dental treatment. The restorative materials used may include plastic fillings, plastic sealants, silver fillings and stainless steel crowns. Restorative treatment may include tooth nerve removal when necessary. Surgical treatment may include but not be limited to tooth removal and minor gum problems. Local anesthesia and nitrous oxide and oxygen are used routinely as needed for your child's comfort.

No sedative drugs are used without prior consent by parent. If it becomes necessary due to a cooperation problem to control or relax the patient by the use of sedatives, you will be consulted in advance. Physical restraint is not used without a parent's consent.

I acknowledge that I will be responsible for arranging for payment of any bills incurred on the above child for dental treatment. I understand that all charges are due and payable upon receipt of my monthly statement and all delinquencies are subject to outside collections and that I may be responsible for attorney fees and reasonable collection costs. I also agree to and understand that interest may be assessed on any unpaid balance over sixty (60) days delinquent.

Signature _____ Witness _____

Relationship _____ Witness _____