

DEMOGRAPHIC INFORMATION

Date _____

Patient _____

Name your child would like to be called _____

Age _____ Birthdate _____ Sex _____ Home Phone _____

Email _____

Preferred number at which we can contact you if needed _____ **Emergency** _____

Home Address _____

Names and ages of other children in the family _____

School _____ Grade _____

Mother _____ SS# _____

Mother's employer _____ Phone _____

Father _____ SS# _____

Father's employer _____ Phone _____

Who has legal custody of patient _____

Who will be responsible for the account _____

Policyholder's name & date of birth _____

Dental insurance _____ yes _____ no Company _____

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 examination _____

___ ___ Has your child ever had a health problem? _____

___ ___ Has your child ever been hospitalized? Please give reasons and dates _____

___ ___ Is your child allergic to anything? _____

___ ___ Is your child currently taking any medications? Please give medications and reason _____

___ ___ Were there any problems at birth?

Please check if your child has been treated for any of the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sensory/Processing Disorder |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cleft lip/palate | |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> AIDS | <input type="checkbox"/> Other problems | |

Please elaborate _____

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 _____

DENTAL HISTORY

Yes No

___ ___ Has your child ever been to the dentist? Name of the dentist and date _____

___ ___ Has your child experienced any unfavorable reaction from previous dental care? Please explain _____

___ ___ Does your child suck a finger, thumb, or pacifier? **If yes**, Please circle which one.

___ ___ Does your child have pain with chewing, yawning, or wide opening?

___ ___ Does your child's jaw make a noise and is there pain associated with the sounds?

Who brushes your child's teeth and how often? _____

Please check if your child is having problems with any of the following:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Teeth sensitivity |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum infections | <input type="checkbox"/> Color of teeth |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw sounds | <input type="checkbox"/> Other |

Comments _____

Is there any additional information we should know that will help us provide a positive dental experience for your child? _____

FLUORIDE HISTORY

Yes No

___ ___ Is your home water supply fluoridated?

___ ___ Does your child use a fluoride toothpaste? Were they using it before two (2) years old? _____

___ ___ Do you give your child any other form of fluoride? What? _____

___ ___ Does your child participate in a school fluoride rinse program?

CONSENT for DENTAL TREATMENT

I request and authorize Dr. Brooks/Dr. Chandak (and staff at their direction) to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Brooks/Dr. Chandak 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. Brooks/ Dr. Chandak provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, and demonstration procedures and instruments, and using variable voice tone. Occasionally the need for gentle arm or leg restraint is required to safely complete a procedure. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ Date _____

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APPOINTMENT POLICY

We are aware of school policies that make it difficult for children to be out of school for any reason. However, **MEDICAL** and **DENTAL** appointments are **EXCUSED ABSENCES** with a doctor's school note and signature stating that the child was in the office.

Although we would like to see all school-age patients after school, this is not possible. Therefore, to make certain everyone has a fair share of after school appointments, the following guidelines have been set. Please help your child and others by not asking for exceptions.

- 1) A **parent or legal guardian** must accompany any child under the age of eighteen to all appointments.
- 2) For your safety and the safety of our patients and our staff we respectfully request that **NO FOOD, DRINKS, STROLLERS, OR CELL PHONES** be in any treatment areas.
- 3) Children six and under will be scheduled only between the hours of 8:20 and 11:40 AM. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- 4) Operative appointments (fillings, extractions, etc.) for **all** children will only be available during the morning hours.
- 5) Six-month oral examinations and cleaning appointments for school-age children will alternate between school and after school hours. This means you will be asked to bring your child during school hours only once or twice per year.
- 6) Repair or broken appliance appointments will be scheduled during school time.
- 7) Coming in 15 minutes late for any appointment may **require rescheduling** so we do not keep other patients waiting. Please call if you are going to be late. This will be considered a Broken Appointment.
- 8) If for any reason you fail to come or cancel for an after school appointment, the missed appointment will be rescheduled during school time so that we may maintain the pattern of every other appointment after school.
- 9) We reserve the right to charge a \$40.00 missed appointment fee for broken/missed appointments. Broken appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 24 hour notice, our office reserves the right to **NOT** schedule any subsequent appointments.

Your cooperation in complying with these guidelines is appreciated. We are concerned with school policies and believe these schedules will best benefit every patient. It is our desire to serve each and every one of you without causing your child to miss extensive school time. We appreciate you choosing our office for your child's dental care.

SIGNATURE _____ DATE _____



Richard F. Brooks, D.D.S., Ritu K. Chandak, D.D.S.

members, American Academy of Pediatric Dentistry
Board Certified Diplomates, American Board of Pediatric Dentistry
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