

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 _____