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WELCOME!

We welcome your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your child's dental health. All questions contained in this questionnaire are strictly confidential and will become part of your child's dental record.

Is there anything about your child that we should know or consider before working with him or her?

Name (Last, First, MI): M F Nickname Today's Date / /

Email Birthday / / Age

Residence City State Zip

Home Phone () Child's Cell Phone ()

School Telephone ()

School Address City State Zip

Siblings Yes No Names/Ages

Father		Mother	
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Marital Status Married Divorced Single Parent Legal Guardian Marital Status Married Divorced Single Parent Legal Guardian

Name Name

Email Email

Employer Employer

Work Address Work Address

Work Phone Cell Work Phone Cell

Care Giver Name Cell Phone

Whom may we thank for referring you? Name Phone

Address

City State Zip

Please continue to page 2

Your Child's Eating Habits:	1. How many times a day does your child snack?
	2. Does your child use vitamins? <input type="checkbox"/> Yes If Yes, type: <input type="checkbox"/> No
	3. Does your child drink juice? <input type="checkbox"/> Yes If Yes, how often: <input type="checkbox"/> No
	4. Does your child use a 'sippy' cup or straw? <input type="checkbox"/> Yes <input type="checkbox"/> No

CHILD'S DENTAL HEALTH HISTORY

Date of last dental visit.	/ /	Name of previous dentist:	For what reason:
Has child complained about dental problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Explain?	
Any unhappy dental experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the experience.	
Any injuries to mouth, teeth, or head?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the injury.	
Are there any mouth habits, such as thumb sucking, nail biting, mouth breathing, use of pacifier (please check the box)			
Thumb Sucking	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nail Biting	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Mouth Breathing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Use of Pacifier	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes until what age?		If yes until what age?	
		If yes until what age?	
Have orthodontic appliances ever been worn? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If yes, explain.</i>			
Does your child brush daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Do you assist your child with tooth brushing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Is dental floss used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Do you put your child to sleep with a bottle?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Does your child drink fluoridated water?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you nurse your child to sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your child's nap schedule?			

CHILD'S GENERAL HEALTH HISTORY

Child's physician or pediatrician		Phone	
Address	City	State	Zip
Date of last exam	/ /	Results	

CHILD'S GENERAL HEALTH HISTORY

continued

Is your child under a pediatrician's care now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Pediatrician:	
Is there excessive bleeding when cut?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the child taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>What medication?</i>	
Are there emotional or behavioral issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please Explain</i>	
Has the child ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date / /	<i>Please Explain</i>
Has the child ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date / /	<i>Please Explain</i>
Is the child allergic to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which ones?	
Is your child allergic to latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What are they?	

Has the child any history of or difficulty with any of the following (please check the box): None

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Chronic sinus	<input type="checkbox"/> Eyes	<input type="checkbox"/> Hearing	<input type="checkbox"/> Malignancies	<input type="checkbox"/> Thyroid
<input type="checkbox"/> AIDS – HIV	<input type="checkbox"/> Cleft Lip/Palate	<input type="checkbox"/> Fainting	<input type="checkbox"/> High Fever	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsils / Adenoids
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Kidney	<input type="checkbox"/> Skin	<input type="checkbox"/> History of Trauma to the Face
<input type="checkbox"/> Canker Sore	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Headaches	<input type="checkbox"/> Liver	<input type="checkbox"/> Speech Disorder	<input type="checkbox"/>

Please describe any current medical treatment, including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been discussed.

May we request the release of your child's medical records for our reference?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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I understand that the information that I have provided is correct. It is my responsibility to inform this office of any changes in my child's medical status. I agree that the parent or guardian of the child is responsible for payment.	Print Name Below
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I give my permission for the staff to take dental X-rays of my child.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Initial to the right: _____	By signing below this name, I authorize the dental staff to perform all necessary dental services my child may need.
Relation to the child	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other
			Signature (parent or guardian)

IN CASE OF EMERGENCY

Name of local friend or relative	Relation to child	Home Phone	Work or Cell Phone
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The Parent or Guardian of the child is responsible for payment of dental services.

Thank you for completing our form!