

Children's Dental Center

DATE _____

NAME _____ MALE FEMALE BIRTHDATE _____ AGE _____

MEDICAL HISTORY

PHYSICIANS NAME _____ PHONE _____

Is the child allergic to latex? YES NO

Does this child have any allergies to medication? YES NO

Please describe _____

Has this child ever been hospitalized? YES NO

Please indicate date and reason _____

Is this child presently taking any medication? YES NO

Please list medication, dosage, and reason for taking _____

Does this child have any heart condition? YES NO (If yes, is premedication required)

Please describe any murmur, surgery, prolapse or any other heart problem _____

Does this child have any bleeding disorders? YES NO

Please describe _____

Does this child have a history of seizures? YES NO

Please describe _____

PLEASE CHECK ALL THAT APPLY:

- | | | |
|---|--|---|
| Autism <input type="checkbox"/> | AIDS/HIV Positive <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Cerebral Palsy <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> |
| Learning Disabilities <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| Physical Limitations <input type="checkbox"/> | Sickle cell trait or disease <input type="checkbox"/> | Asthma <input type="checkbox"/> |
| Downs Syndrome <input type="checkbox"/> | Cancer/chemotherapy/radiation <input type="checkbox"/> | Mouth Breather <input type="checkbox"/> |
| Speech or Hearing Problems <input type="checkbox"/> | Anemia <input type="checkbox"/> | Seasonal Allergies <input type="checkbox"/> |
| Pregnant <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Chronic Respiratory Infections <input type="checkbox"/> |

Please describe any conditions marked above or not listed _____

DENTAL HISTORY

Date of last dental visit _____ Dentist name and phone _____

Does this child have any finger, thumb or similar habits? _____

Please describe _____

Is this child nursing? _____ Or using a bottle? _____

Has this child ever injured their teeth or jaw in a fall or other type of accident? YES NO

Please Describe _____

Any comments that may aid us? _____

Please describe the main reason for your visit today _____

Parent/Guardian Signature **X** _____ Relationship to Patient _____

FUTURE VISITS

Health Changes _____

Signature **X** _____ Date _____

CHILDREN'S DENTAL CENTER

Name of child _____

Last

First

Middle

Home Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Father's Name _____

Mother's Name _____

Date of Birth _____

Date of Birth _____

Address (if different) _____

Address (if different) _____

Phone (_____) _____

Phone (_____) _____

Employer Name _____

Employer Name _____

Employer Phone (_____) _____

Employer Phone (_____) _____

Address _____

Address _____

Social Security # _____

Social Security # _____

Driver's License # _____

Driver's License # _____

Emergency Contact Name _____ Phone (_____) _____

Is child covered by dental insurance Yes No

Name of Insurance Company _____ Policy of I.D. # _____

Accounts with balances due over 60 days may be assessed interest at a rate of 1% per month (annual interest rate 12%). In the event of default on the part of the responsible party in the making of any payment when due, this contract may be placed in the hands of a collection agency or an attorney for collection of the amount due plus interest, and he/she will be responsible for the cost of collection, including a reasonable attorney's fee. All accounts 90 days overdue may be turned over for collection.

Signed **X** _____ Relationship to Patient _____

Referred By _____ Date _____