Demographic Information

Patient_____ Today's Date_____
First MI Last

Name child would like to be called_____ Home Phone:_____
Birthday_____ Age_____ Sex_____ Cell Phone:_____
Email: (Print) _____ Text ☐ or Email ☐ appt confirmation OK?
Emergency Contact (Not Parents) Name_____ Phone #_____
School _____ Grade _____
Parent's primary language, if NOT English: _____

Guardian 1: _____ Relation to patient_____
Home Address_____
street *town* *state* *zip code*
Employer_____ Wk Phone_____

Guardian 2: _____ Relation to patient_____
Home Address_____
street *town* *state* *zip code*
Employer_____ Wk Phone_____

Who has legal custody of patient?_____ Dental Insurance: ☐ Yes ☐ No
Name of guardian accompanying child today_____ DOB_____
Name of child's physician/group_____ City/St_____ Ph #_____
Names and ages of other children in family_____
How did you hear about our office? _____
What is the reason for your child's dental visit?_____

Health History

☐ Yes ☐ No Is your child in good health? Date of last physical exam_____
☐ Yes ☐ No Has your child ever had a health problem?_____
☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_____
_____
☐ Yes ☐ No Is your child allergic to anything?_____
☐ Yes ☐ No Is your child currently taking any medications? Please give medication, dose and reason
_____
_____
☐ Yes ☐ No Were there any problems at birth?_____

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

☐AIDS/HIV	☐ Cancer/tumors	☐Eyesight	☐MRSA
☐Adverse drug reactions	☐Cerebral palsy	☐Frequent infections	☐Personality/social
☐Anemia	☐Cleft lip/palate	☐Heart disease/murmur	☐Physical delays
☐Asthma/breathing	☐Congenital birth defects	☐Hepatitis	☐Reflux/GERD
☐Autism	☐Diabetes	☐Kidney disease	☐Rheumatic fever
☐Bleeding/transfusions	☐Down Syndrome	☐Liver/GI disease	☐Seizures
☐Blood dyscrasias	☐Endocrine/growth	☐Mental delays	☐Speech/hearing

Please elaborate on any items marked above:_____
_____
_____

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? Date of last xrays (if taken)_____
Name of dentist and date_____

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care? Explain_____
_____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?_____

☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

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

☐ Cavities	☐ Toothache	☐ Teeth Sensitivity
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____
_____

Office Use Only
☐ Fl- City Water
☐ Pvt. Well
☐ Public Well ____ppm
☐ H_2O test kit given

Fluoride History

☐ Yes ☐ No Do you have well water at your home?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride? What?_____

Consent for Dental Treatment

I request and authorize Dr. Lindsay and/or Coffield 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 the dentist 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. Lindsay and/or Coffield will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ **Date** _____