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Demographic Information

Patient______________________________________Today's Date____________
Name child would like to be called__________________Home Phone______________
Birthday___________ Age______ Sex______ Cell Phone________________________
Patient's SS# __________Parent/Guardian's Email ____________________________
Home Address____
street *town* *state* *zip code*
School______________________________Grade _______________________
Parent/Guardian 1:___________________________Relation to patient___________
DOB______________SS#__________________Marital Status______________
Employer_____________________________________Phone______________
Parent/Guardian 2:___________________________Relation to patient___________
DOB______________ SS#__________________Marital Status______________
Employer _____________________________________Phone______________
Who has legal custody of patient?______________Dental Insurance Company___________
Name of child's physician/group__________________City/St_____Ph #___________
Whom may we thank for referring you to us?____________________________________
What is the reason for your child's dental visit?___________________________________

Names and ages of other children in family ____________________________________

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?___________________________________
Yes No Any history of alcohol, tobacco or substance abuse?______________________
Yes No Is your child taking birth control or pregnant?____________________________

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

Heart disease	Bleeding/transfusions	Asthma/breathing	Blood dyscrasias	Liver/GI disease	Anemia
Diabetes	AIDS	Kidney disease	Rheumatic fever	Hepatitis	Mental delays
Speech/hearing	Seizures	Cleft lip/palate	Physical delays	Eyesight	Cancer/tumors
Personality/social	Other problems	Congenital birth defects	Autism	Recurrent headaches	Frequent infections
Cerebral palsy	Significant injuries	Endocrine/growth	Adverse Drug reactions		

Please elaborate on any items indicated:____

____

____

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 Sensitive
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 Is your home water supply fluoridated?

Yes No Does your child use a fluoride toothpaste?

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

Yes No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Barbee 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. Barbee 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. Barbee 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 ____________________