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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 _____