

Health and Dental Information

(Children 12 & Under)

Patient's Name: _____ **Is This the Patient's 1st Dental Appointment?** Yes No

If No, Date of Last Dental Exam: _____ Dentist's Name: _____ City & State: _____

Your Name: _____ Phone: _____ Relationship: _____

Emergency Contact:(If Not Listed Above)
Name: _____ Phone: _____ Relationship: _____

Patient's Physician: _____ Phone: _____ City & State: _____

Date of Last Physical Examination: _____

Has the Patient Ever Been Hospitalized or Had Surgery? Don't Know Yes No

If Yes, Please Give Reasons, Dates: _____

Have Instructions Ever Been Given for the Patient to Take ANY Medications or Special Precautions Before Any Dental Appointments*? Don't Know Yes No

If Yes, Please Explain: _____

What Type of Water is the Patient Drinking?

City/Village Water Well Water Bottled Water Don't Know

Is the Water Fluoridated? Don't Know Yes No

Is a Water Purifier Used? Don't Know Yes No

Does the Patient Take Any Additional Fluoride Supplements? Don't Know Yes No

If Yes, What Type?

Multi-Vitamin with Fluoride Fluoride Drops Fluoride Gel Don't Know

Chewable Fluoride Tablets Fluoride Liquid Mouth Rinse

What Brand? _____

1. Is The Patient Taking ANY Other Drugs, Medications, or Treatments at This Time? Don't Know Yes No

(If You Brought a Complete Written List With You, Give That to the Receptionist Instead)

Prescribed _____

Over- The- Counter Medications, Vitamins, Etc. (Such as Allergy Medication, Etc.)

2. Is the Patient Allergic to or Ever Experienced an Unusual Reaction to:

Latex Metals or Jewelry Dental Anesthesia (Local)
 Fluoride General Anesthesia Nitrous Oxide (Laughing Gas)

3. Has the Patient Had An Allergic Reaction or Unusual Response to ANY Medications, Drugs, Pills, or Treatments? Yes No

If Yes, Please List : _____

Does the Patient Have or Had Any of the Following Problems or Conditions: (Please Check Yes or No for Each Question)

4.	Yes	No	5.	Yes	No
a. Congenital Heart Defects*	___	___	a. Asthma	___	___
h. Rheumatic Heart Disease / Rheumatic Fever*	___	___	b. Hay Fever, Skin or Food Allergies, or Allergies in General	___	___
i. Heart Murmur*	___	___	c. Sinus Problems	___	___
j. Heart Valves Damage / Mitral Valve Prolapse*	___	___	d. Tuberculosis, Emphysema or Lung Disorder	___	___
r. Excessive Bleeding from Any Cut or Incident	___	___	e. Skin Problems	___	___
s. Diabetes or Blood Sugar Problems	___	___	j. Epilepsy or Other Seizure Disorder	___	___
t. Any Artificial Joint, Joint Surgery,*	___	___	k. Any Kidney Problems	___	___
u. Hepatitis, Jaundice, or Other Liver Problems	___	___	m. A Compromised Immune System*	___	___
v. Any Form of Cancer	___	___	o. Any Mental Health Issues	___	___
w. An Organ Transplant*	___	___	q. Attention Deficit Disorder (ADD)	___	___

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Dental and Oral Health Information

Has the Patient Ever Had Braces or Any Other Type of Orthodontic Treatment? Don't Know Yes No
Dentist's Name and Approximate Dates of Treatment: _____

Has the Patient Ever Had Any Type of Oral Surgery? Don't Know Yes No
Dentist's Name and Approximate Dates of Treatment: _____

Does the Patient Have or Had Any of the Following: (Please Check Yes or No for Each Question)

	Yes	No		Yes	No
Teeth that are Sensitive to: Heat	___	___	Clenching or Grinding Teeth	___	___
Cold	___	___	Clicking or Snapping When Chewing	___	___
Sweets	___	___	Difficulty Opening or Moving the Jaws	___	___
Biting Pressure	___	___	Difficulty Chewing or Swallowing	___	___
An Unpleasant Taste or Bad Breath	___	___	Difficulty Speaking, or Talking	___	___
Bleeding Gums or Sores	___	___	Difficulty Moving Their Tongue or "Tongue Tied"	___	___
Any Lumps or Swelling in the Gum Tissue or Mouth	___	___	Had Any Adult Teeth Removed	___	___
Avoid Any Part of Their Mouth	___	___	Have a Thumb, Finger or Pacifier Sucking Habit?	___	___
When Brushing or Chewing	___	___			

How Many Times Daily Are Their Teeth Brushed? _____ **How Many Times a Week Are They Flossed?** _____

Does the Patient Regularly Use Any of the Following Dental Hygiene Aids? Don't Know Yes No
Electric, Mechanical, or Sonic Toothbrush, or Similar Appliance?

If Yes What Brand or Type: _____

Flossing Aids? Don't Know Yes No

If Yes What Brand or Type: _____

Mouthwashes or Oral Rinses? Don't Know Yes No

If Yes, What Brand? _____

Oral Irrigating Device (Water Pik) Don't Know Yes No

Does the Patient Have Any Physical Limitations, Dental Fear or Complications From Past Dental Care that May Interfere with Dental Treatment? Yes No

Has the Patient Ever Had Any Major Trauma or Injury to Their Head, Neck, Mouth, or Teeth? Yes No

If Yes, Please Specify: _____

7. Does the Patient Have Any Other Conditions, Diseases, Dental, or Medical Problems, or Is There ANY Other Information That You Think We Should Know About or Be Made Aware Of?

If So, Please Explain: _____

APPOINTMENTS— A minimum charge will be made for failed or canceled appointments without prior notification of at least 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved just for you. Any change in your appointments affects many patients; please be considerate.

INSURANCE—For your convenience, we will complete any forms required by your dental insurance company. Your signature below authorizes the release of any information regarding your dental claims to your insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay any or all of our charges. Each fee is individual for the individual patient.

PAYMENT— Payment is expected when services are rendered, unless other arrangements are made in advance. A service charge of 2% per month (equivalent to 24% PER ANNUM), will be added to the unpaid balance of all account over 30 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses, including all collection agency fees, court costs and reasonable attorney's fees.

CONSENT—To the best of my knowledge, all of the preceding answers are correct. If I ever have any change in my health, or if my medications change, I will inform this office at the next appointment without fail. I hereby consent to allow diagnosis, proper dental care and treatment to be performed by this practice for myself or the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature of Parent or Guardian _____ Date _____

Do We Need these Questions????????????????

3. Are You Allergic to or Have You Ever Had Any Reaction to Any of the Following Drugs?

- | | | | |
|--|---|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin (or Related Drugs) | <input type="checkbox"/> Tranquilizers (Valium) | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Aspirin / Ibuprofen (Advil, Motrin, Nuprin) | <input type="checkbox"/> Keflex (Cephalexin) | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> NSAID (Celebrex, Vioxx, Anaprox) | <input type="checkbox"/> Clindamycin (Cleocin) | <input type="checkbox"/> Erythromycin | |

Is Fluoride Toothpaste Used? (Do we need This Question? Aren't All Fluoridated?)

What Brand of Toothpaste Does the Patient Use? (Is this a better Question?) **Some herbal preparations are not fluoridated**

Cerebral palsy, growth problems i.e.: Marfan's

At What Age did the Child Stop: (Do We Need this Question?)

- Bottle Feeding___
- Breast Feeding___
- Using a Sippy Cup___

Are you Concerned About the Finances Required to

Return the Child's Mouth to Excellent Health? (Do We need this question on the child's Dental Form??) **no**

Chronic Ear Infections Etc??

Add To PW Med Alerts

5q. Attention Deficit Disorder (ADD)