Name: _____ Date: _____

Date of Birth: _____

What is the primary reason for today's visit?

_____

_____

Has the child experienced problems with previous dental work?	▫ Yes	▫ No
Is the child's water fluoridated?	▫ Yes	▫ No
Is the child taking fluoride supplements?	▫ Yes	▫ No
Has child ever experienced an injury to mouth, teeth, jaw?	▫ Yes	▫ No
Has child ever had any pain/tenderness in his/her jaw joint?	▫ Yes	▫ No
Does the child brush his/her teeth daily?	▫ Yes	▫ No
Does the child floss his/her teeth daily?	▫ Yes	▫ No
Immunizations Current?	▫ Yes	▫ No

Please list all prescription/nonprescription medications the child is currently taking: _____.

Allergies: (Please circle) ***None***

Penicillin Latex Codeine Erythromycin Tetracycline Sulfa Dental Anesthetics Metals/Jewelry Aspirin Foods (List)

Other: _____

Please describe the child's current physical health:

Good _____ Fair _____ Poor _____

Does/Did the child experience any of the following:

Y	N	Dental Trauma
Y	N	Lip Sucking/Biting
Y	N	Chewing on Objects
Y	N	Mouth Breathing
Y	N	Clenching/Grinding Teeth
Y	N	Used Pacifier (to age_____)
Y	N	Nursing Bottle Habits
Y	N	Thumb/Finger Sucking (to age _____)
Y	N	Tongue/Cheek Biting
Y	N	Speech Problems
Y	N	Tongue Thrust
Y	N	Breast Fed (to age _____)
Y	N	Tongue Piercing
Y	N	Smoking/Tobacco Use

Does your child have a diagnosed heart murmur or heart problem for which antibiotic premed is required prior to dental appointments? _____

Child's Cardiologist: _____Ph.#: _____

Child's Physician: _____ Ph. #: _____

Anything you would like to discuss with the Doctor in Private?

_____

Has the child experienced the following medical problems?

(Please Circle Identified Problems/Issues)

Abnormal Bleeding	Congenital Heart Defect	Hepatitis	Mononucleosis
ADD/ADHD	Convulsions/Epilepsy	High Blood Pressure	Rheumatic Fever
AIDS	Diabetes	Hives	Scarlet Fever
Anemia	Exposed to HIV, but Neg.	HIV Positive	Skin Rash
Asthma	Handicaps/Disabilities	Kidney Problems	Tuberculosis
Cancer	Hearing Impairment	Low Blood Pressure	***None of Above***
Chicken Pox	Heart Murmur	Lupus	Other _____
	Hemophilia	Measles	_____

Our office is HIPAA Compliant and is commited to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need including, but not limited an exam, cleaning, x-rays, and fluoride application based on clinical necessity and the current standard of care set forth by the American Academy of Pediatric Dentistry. Further, I understand I am responsible for charges not covered by my insurance plan unless I specifically request in writing that certain procedures not be performed on the service. By my signature, I also certify and affirm that I am the legal guardian of this patient and as such have the legal right and responsibility to provide all consents relating dental care recommended by Dr. Fales and his staff.

_____ _____

Signature of Parent/Guardian **Date**

Reviewed by: _____ **Doctor's Comments:** _____