## Child Dental History

Date of last visit to a dentist? _____ For what services? _____

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Has child complained about dental problems? | ❑ | ❑ | Is fluoride taken in any form? | ❑ | ❑ |
| Does child brush teeth daily? | ❑ | ❑ | Any injuries to mouth, teeth, head? | ❑ | ❑ |
| Does child use floss every day? | ❑ | ❑ | Any unhappy dental experiences? | ❑ | ❑ |

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? _____

Please list any other dental concerns: _____

## Child Medical History

Minor/Child's Physician _____ Phone _____

Date of last physical examination _____ Results _____

| | Yes | No |
|---|---|---|
| Is Minor/Child under care of physician now? | ❑ | ❑ |
| Receiving any medication or drugs? | ❑ | ❑ |
| Ever been hospitalized? | ❑ | ❑ |
| Ever had surgery? | ❑ | ❑ |
| Is there excessive bleeding when cut? | ❑ | ❑ |

Medications _____

_____

_____

Allergies _____

_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLWING? IF YES, PLEASE CHECK ( ✓)

| | | | | |
|---|---|---|---|---|
| ❑ AIDS/HIV | ❑ Cerebral Palsy | ❑ Epilepsy | ❑ Kidney Desease | ❑ Rheumatic Feaver |
| ❑ Anemia | ❑ Chicken Pox | ❑ Fainting | ❑ Liver Desease | ❑ Sinus Problems |
| ❑ Asthma | ❑ Convulsions | ❑ Hearing Impaired | ❑ Measles | ❑ Thyroid Disease |
| ❑ Bladder Problems | ❑ Diabetes | ❑ Heart Problems | ❑ Mononucleosis | ❑ Tuberculosis |
| ❑ Cancer | ❑ Drug/Alcohol Abuse | ❑ Hepatitis | ❑ Mumps | ❑ Other |

## Emergency Contact Information

In the event of an emergency, please list contacts not residing with you.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

## Consent for Services

I acknowledge that deductibles, co-insurance or full payment is due at the time of treatment, unless other arrangements are made **prior to treatment.** I accept full financial responsibility for all charges not covered by insurance. I understand claims will be released to me for full payment if insurance has not responded with payment within 60 days. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and have filled it out to the best of my knowledge.

_____ _____

Date Signature of Responsible Party