DATE:_____/_____/_____

CONFIDENTIAL
HISTORY AND CONSENT FORM

Child's Name_____ Birth Date _____/_____/_____

How does your child like to be referred to (nick name, etc.) _____

Parent's Name (Guardian) _____

Home Address _____ Phone No. _____

Person Financially Responsible (if other than parent) _____

Relationship to Child _____

Billing Address (if other than home address) _____

Occupation: Father _____ Mother _____

Place of Employment: Father _____ Phone No. _____

Mother _____ Phone No. _____

Dental Insurance: Yes_____ No _____ Insured Birth Date _____/_____/_____

Name of Company _____ Policy No. _____

Address _____

Medicaid (Welfare) No. _____

Father's Social Security No. _____ Mother's Social Security No. _____

Child's Physician _____ Phone No. _____

Physician's Address _____

Child's Former Dentist _____ Phone No. _____

Dentist's Address _____

Date of Last Dental Visit _____

Whom may we thank for referring you? _____

Address _____

May we request release of your child's medical records for reference? Yes _____ No _____

I hereby certify that the information contained in these forms is accurate and complete to the best of my knowledge

Signature _____ Date _____/_____/_____

Relationship _____

MEDICAL HISTORY

Please answer the question by checking either Yes or No. If you are not sure, leave it unanswered.

1. Is your child currently under a physician's care for any reason? Yes _____ No _____
If Yes, describe _____
_____

2. Has your child ever been hospitalized? Yes _____ No _____
If Yes, describe reason for admission and date _____
_____

3. Is your child currently taking any medication? Yes _____ No _____
If yes, write name, dose and how often taken _____
_____

4. Has your child ever had an unusual or allergic reaction to any of the following?
PENICILLIN Yes _____ No _____ ASPIRIN Yes _____ No _____ CODEINE Yes _____ No ____
LOCAL ANESTHETIC Yes _____ No ____ OTHER ANTIBIOTICS Yes _____ No _____
Describe _____

5. Is your child sensitive or allergic to anything else? (i.e. food, animals, ect.) Describe _____

6. Has your child had any of the following? (Please circle letter)

a. anemia (weak blood)	g. continuous colds	m. heart murmur	s. pneumonia
b. asthma	h. diabetes	n. hepatitis (jaundice)	t. rheumatic fever
c. bladder problems	i. epilepsy	o. kidney disease	u. scarlet fever
d. bleeding problems	j. fainting spells	p. leukemia	v. speech problems
e. cancer	k. hearing problems	q. lung disease	w. thyroid condition
f. convulsions (seizures)	l. heart disease	r. mononucleosis	x. tuberculosis

Please describe any that are circled (unless already mentioned elsewhere) _____
_____
_____
_____

Please describe any other medical problems not listed here _____
_____

DENTAL HISTORY

Please answer the question by checking either Yes or No. If you are not sure, leave it unanswered.

1. Has your child ever been under the care of a dentist? Yes _____ No _____
If yes, name of dentist and last visit _____
Please circle letter of type of care
a. emergency pain relief (toothache) c. fillings
b. tooth taken out d. other, describe _____

2. Has your child complained of dental problems? Yes _____ No _____
a. For how long? _____
b. Describe location of pain (i.e. top right, lower left, etc.) _____

3. Does your child have any of the following habits (please circle letter)
a. thumb or finger sucking c. lip sucking or biting e. other _____
b. mouth breathing d. teeth grinding

4. Has your child ever had an unpleasant dental experience? Yes _____ No _____
If yes, describe _____

5. Does your child now take fluoride in any form other than toothpaste? Yes _____ No _____
Circle type PILL LIQUID VITAMIN

6. Is there any specific dental problems you with to discuss with the doctor? Yes _____ No _____
Describe _____