5 DENTAL INFORMATION

Is this visit the child's first trip to a dentist? ☐ Yes ☐ No

Any unfavorable reaction to medical/dental appointments? ☐ Yes ☐ No

Any dental/mouth habits? ☐ Yes ☐ No

Is child taking a fluoride supplement?

Drops ________ Vitamins ________ Rinse ________ Other ________

Any previous injuries to mouth/teeth? ________________ Date ________

Child's previous dentist ________________ Date ________

At what age was child taken off bottle? ________________

List any specific dental problems ________________________________

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6 MEDICAL HISTORY

Is your child in good health? ________________________

Has your child had any history of:

Y N Rheumatic Fever	**Y N** Diabetes	**Y N** Brain Damage
Y N Heart Trouble	**Y N** Kidney Problems	**Y N** Circulation
Y N Mitral Valve Prolapse	**Y N** Liver Problems	**Y N** Blood Disorders
Y N Asthma	**Y N** Epilepsy	

Is your child allergic to any foods, drugs, or latex? If so, please list ________________________

Is there any history of excessive bleeding in child ____________ or family member ____________ ?

Is your child under medical care at the present time?

Reason ____________________ Physician ____________________

Has your child had any condition which might affect dental treatment? ________________________

Is there any reason, to your knowledge, why a local anesthetic cannot be used? ________________

Is your child taking any medicine now? ________________________________

Medication ____________________ Reason ____________________

Does your child have a special physical ____________ or mental handicap? ____________

Is special treatment required? ____________

- ***We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.***
- ***Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Office Manager. If account is not paid within 90 days of the date of service you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.***
- ***I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.***
- ***I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it's my responsibility to inform this office of any changes to the information I have provided.***
- ***I have received a copy of the patient credit policy. (Initials)*** ________

Signature: ____________________ **Date** ____/____/____