



Patient Information

Patient _____ Date _____

Name child would like to be called _____ Birthday _____ Age _____ Sex _____

Names/birth dates of other children in family _____

Street Address _____ City _____ Zip _____

Mailing Address(if different) _____

Home Phone _____ Cell Phone _____ E-mail _____

Mother _____ Birth date _____ Employer _____

Social Security Number _____ Work Phone _____

Father _____ Birth date _____ Employer _____

Social Security Number _____ Work Phone _____

Who has legal custody of patient? _____

Person responsible for payment of account _____

Whom may we thank for referring you? _____

What is the reason for your child's dental visit? _____

Health History

Is your child in good health ? Yes ___ No ___ Name of physician _____

Physician phone number _____ Date of last exam _____

Has your child ever had a health problem? _____

Are your child's immunizations up to date? Yes ___ No ___

Has your child had any operations? Yes ___ No ___

Is your child currently taking any medications? Please list medications, dose and reason.

Were there any problems at birth? _____

Is your child allergic to anything?List _____

Please check the box if you child has been diagnosed and/or treated for any of the following:

AID/HIV Diabetes Hepatitis Tuberculosis Mental delays Physical delays

Anemia Seizures Kidney disease Birth defects Social delays Speech/Hearing

Asthma Excessive bleeding Liver disease Cerebral Palsy Cleft Lip/Palate Heart Murmur

Blood Disorder Rheumatic fever Cancer/Tumors Stomach/GI disease Immune Disorders Other

Please elaborate on any item checked _____

Reviewed by _____

Dental History

Has your child ever been to the dentist? Yes No Date of last visit _____

Name of dentist _____

Has your child ever had dental x-rays? Yes No Date _____

Do you think your child will react well to dental treatment? Yes No

Explain _____

Does your child suck a thumb, finger, pacifier? Yes No What age(s) _____

Does your child brush his/her teeth? Yes No How often? _____

Does your child use dental floss? Yes No How often? _____

Does your child have snacks between meals? Yes No _____

Have your child's teeth ever been injured? When? Which ones? _____

Does your child's jaw make noise and is pain associated with the sounds? Yes No

Please check if your child is having problems with any of the following:

Cavities Toothaches Sensitive Teeth Gum Infections

Color of teeth Crooked Teeth Jaw Pain Other _____

Was your child : Breast fed Bottle fed At what age did it cease? _____

Fluoride History

Is your home water supply fluoridated? Yes No

Does your child use fluoride toothpaste? Yes No

Does your child use a fluoride supplement? Yes No Dose? _____

Do you give your child any other forms of fluoride? Yes No What? _____

Consent for Dental Treatment

I authorize Dr. Harmon, Dr. Owensby and staff to examine, clean and provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Harmon and/or Dr. Owensby to diagnose or treat my child's dental condition. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Harmon and Dr. Owensby will provide an environment likely to help children cooperate during treatment by providing praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred by this child for dental treatment.

Signature _____

Date _____