

Pediatric Dental Specialists, PLLC
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PEDIATRIC DENTISTRY

Child's Name: _____ Nickname: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: Male Female

Father's Name: _____ Address: _____

City, State: _____ Zip Code: _____ Phone: _____

Father's DOB: _____ Father's SSN: _____

Employed By: _____ Position: _____ Bus. Phone: _____

Mother's Name: _____ Address: _____

City, State: _____ Zip Code: _____ Phone: _____

Mother's DOB: _____ Mother's SSN: _____

Employed By: _____ Position: _____ Bus. Phone: _____

Other Children in the family, and their ages: _____

Do you have dental insurance that may cover part of this professional service? _____

Whom may we thank for referring you? _____

DENTAL HISTORY

What is your main dental concern? _____

Any lost teeth? YES NO

Is this your child's first visit to the dentist? YES NO

Does your child brush daily? YES NO

Who was the last dentist seen? _____

Do you help your child brush? YES NO

Last date patient's teeth were cleaned _____

Is dental floss used? YES NO

Has child complained about dental problems? YES NO

Is fluoride taken in any form? YES NO

If yes, explain: _____

Do you have well water? YES NO

Any unhappy dental experiences? _____

Any Comments, Requests, or Concerns: ____

Any injuries to mouth, teeth, or head? _____

Any mouth habit—thumb, pacifier, nail biting, etc.? _____

MEDICAL HISTORY

Child's Physician: _____ Address: _____ Phone: _____

Date of Last Physical: _____ Results: _____

Is child under the care of a physician now? _____

Is child receiving any medication or drugs? If so, please list: _____

Is there any excessive bleeding when cut? _____

Has child ever been hospitalized? If yes, please explain: _____

Has child ever had surgery? If yes, please list: _____

Is there any allergy to penicillin or other drugs? If yes, please list: _____

Does child have good physical coordination? _____

Are there any emotional issues? If yes, please explain: _____

Any history of problems with local/general anesthesia? _____

DOES CHILD HAVE ANY HISTORY WITH THE FOLLOWING:

____ ADHD/ ADD	____ Cerebral Palsy	____ Hearing	____ Rheumatic Fever
____ Anemia	____ Chronic Sinus	____ Heart Murmurs	____ Thyroid
____ Anxiety/Depression	____ Convulsions	____ Kidney	____ Tuberculosis
____ Asthma	____ Diabetes	____ Liver/Hepatitis	____ HIV/AIDS
____ Autism	____ Down Syndrome	____ Malignancies	____ Other, explain:
____ Bladder	____ Epilepsy	____ Mononucleosis	_____

PERMIT FOR TREATMENT UPON A MINOR

Child's Name: _____ Age: _____

I, being the parent or guardian of the above minor patient, do hereby authorize and request the performance of dental services for this patient; and further, the performance of whatever procedures the judgment of the above named doctors may deem necessary during the performance of any dental treatment.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by the doctor, with my knowledge.

Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment. I also understand that payment for treatment rendered is expected at the end of each appointment, unless other financial arrangements are made.

Parent/Guardian Signature: _____ Date: _____