Davis
PEDIATRIC DENTISTRY

PATIENT HISTORY

Child's Name: _____ Birthdate: _____
first middle last
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ School: _____ Grade: _____
Father's Name: _____ SS#: _____
Occupation: _____ Employer: _____
Employment Address: _____ Phone: _____
Mother's Name: _____ SS#: _____
Occupation: _____ Employer: _____
Employment Address: _____ Phone: _____
Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Other
Last Dental Visit: _____ Dr: _____ Family Dentist: _____
Child's special interests or hobbies: _____
Name and ages of other children: _____
Name of a person who can get in contact with you if you cannot be reached: _____
Phone Number: _____
Name of Dental Insurance: _____
Person responsible for this account: _____
Whom may we thank for referring you? _____

CHILD'S MEDICAL HISTORY

Has your child had any of the following? (please mark all that apply)

☐ Rheumatic Fever	☐ Allergies	☐ Hyperactivity	☐ Kidney Disease
☐ Heart Disease	☐ Seasonal Hay Fever	☐ Cerebral Palsy	☐ Liver Disease
☐ Heart Murmur	☐ Headaches	☐ Brain Damage	☐ Hepatitis
☐ Asthma	☐ Epilepsy/Seizures	☐ Hearing Disorder	☐ Diabetes
☐ Bleeding Disorder	☐ Airway Problems	☐ Speech Disorders	☐ AIDS
☐ Anemia	☐ Blood Transfusions		

Is your child up-to-date on immunizations? ☐ yes ☐ no
Has your child had any bad or allergic reaction to any drug or medicine? ☐ yes ☐ no
Which drug(s)? _____
What was the reaction? _____
Is your child presently taking any medications? ☐ yes ☐ no
List medications: _____
Has your child ever been hospitalized? ☐ yes ☐ no _____
When: _____
Why: _____
Any additional medical or other information that we should be aware of? _____
_____

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DENTAL HISTORY

Is this your child's first dental visit? ☐ yes ☐ no

If no, how was prior visit accepted? _____

Has your child had any of the following? (please mark all that apply)

☐ Abscess ☐ Toothache ☐ Broken Teeth ☐ Trauma to Mouth

☐ Jaw Joint Pain ☐ Jaw Joint Popping ☐ Mouth Breathing

Does your child have any of the following habits? (please mark all that apply)

☐ Sucks Thumb or Fingers ☐ Grinds Teeth ☐ Pacifier ☐ Sucks Lips

How often/when does your child brush his or her teeth? _____

Does anyone help with brushing or flossing? ☐ yes ☐ no

Is your water fluoridated? ☐ yes ☐ no

Any other fluoride supplements? ☐ yes ☐ no List fluoride supplements: _____

Has your child had dental x-rays? ☐ yes ☐ no When? _____

Has your child or any other family member had orthodontic treatment? _____

CONSENT FOR TREATMENT

Because your child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any necessary procedures can be started. This consent gives Davis Pediatric Dentistry permission to perform any dental treatment that may be indicated, as well as emergency medical treatment, if needed. Consent is also granted for such medications, anesthetics and x-rays that may be indicated. All risks and treatment will be explained as necessary.

Signature: _____

Relationship: _____ Date: _____

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BROKEN APPOINTMENT OFFICE POLICY

Due to the number of appointments that are broken without notice, the following policy is in effect. This policy will help to keep Davis Pediatric Dentistry from raising fees. We do not believe it to be fair for those individuals who keep or cancel their appointments within a reasonable time period to bear the financial burden of those who choose not to give any notice for their broken appointment.

If you fail to keep your appointment and give no notice, you are responsible for a broken appointment fee of:

$50.00 for any half hour appointment

This fee must be paid before your child can be rescheduled. Davis Pediatric Dentistry will only be responsible to see your child for emergencies for thirty days from the date of your broken appointment.

Signature: _____ Date: _____

Parent or Legal Guardian

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MEDICAL HISTORY UPDATE

Child's Name: _____

Has there been ANY change in your child's health since his or her last visit? ☐ yes ☐ no

If yes, please explain: _____

Is your child currently taking any medications? ☐ yes ☐ no

If yes, please list medications and dosages: _____

_____

Has your child developed any allergies? ☐ yes ☐ no

If yes, please explain: _____

Has your child been hospitalized or treated by a physician for any illness? ☐ yes ☐ no

If yes, please explain: _____

Is there any other information that you feel we should be aware of before treating your child? ☐ yes ☐ no

If yes, please explain: _____

_____

Is your child up-to-date on immunizations? ☐ yes ☐ no

Please list any change in your address or telephone number since your last visit:

Address: _____ City: _____ State: _____ Zip: _____

Phone: (work) _____ (home) _____ (cell) _____

Signature: _____

Parent or Legal Guardian

Relationship: _____ Date: _____