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CHILD'S NAME _____

DATE OF BIRTH ___ / ___ / ___ **AGE** ___ **WEIGHT** ___ lbs.

MALE ___ **FEMALE** ___

SCHOOL OR DAYCARE NAME _____

NAME OF SIBLINGS _____

HOW DID YOU HEAR ABOUT OUR OFFICE _____

DENTAL HISTORY:

PURPOSE OF TODAY'S VISIT _____

DATE OF LAST EXAM _____ **LAST X-RAYS** _____

ANY UNFAVORABLE DENTAL EXPERIENCES? _____

PLEASE (X) ANY WHICH APPLY TO YOUR CHILD:

_____ **INJURY TO MOUTH OR TEETH** Explain _____

_____ **ORAL HABITS: Thumb/Finger sucking** _____ **Pacifier** _____ **Nail biting** _____
_____ **Tongue thrust** _____

_____ **SENSITIVE/PAINFUL TEETH: Daytime** _____ **Nighttime** _____

_____ **GRINDING OF TEETH: Daytime** _____ **Nighttime** _____

FREQUENCY OF BRUSHING ___ **Times per day** _____ **DOES PARENT HELP** _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Circle one: Y= Yes, N=No

Y N HEART MURMUR

Y N CONGENITAL HEART DEFECT

Y N DIABETES

Y N HIV VIRUS/AIDS

Y N BLOOD DISORDER/TRANSFUSIONS

Y N RHEUMATIC FEVER

Y N CANCER/ TUMOR

Y N KIDNEY/LIVER DISEASE

Y N MENTAL HANDICAP

Y N PHYSICAL HANDICAP

Y N SICKLE CELL ANEMIA
Y N HEPATITIS/ JANDICE
Y N TUBERCULOSIS
Y N CONVULSIONS/EPILEPSY
Y N ASTHMA
Y N SINUS/ ALLERGY PROBLEMS

Y N HEARING IMPAIRMENT
Y N SPEECH IMPAIRMENT
Y N HYPERACTIVE/ ADHD/AUTISM
Y N HOSPITALIZATION
Y N SURGERY

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE OR OTHER PROBLEMS NOT LISTED:

MEDICATIONS THE CHILD IS TAKING NOW? _____

MEDICATIONS OR FOOD THE CHILD IS ALLERGIC TO? _____

CHILD'S PHYSICIAN _____ PHONE _____

PHYSICIAN'S ADDRESS _____

DATE OF LAST EXAM _____

FAMILY ORTHODONTIST'S NAME _____ CITY _____

HAS YOUR CHILD SEEN THE ORTHODONTIST? YES NO LAST EXAM _____

FAMILY MEMBERS WHO SEE THE ORTHODONTIST _____

EMERGENDY CONTACT (Relative or friend not living with you) NAME _____

RELATIONSHIP TO PARENT _____ PHONE _____

DENTAL INSURANCE IMFORMATION:

DENTAL INSURANCE COMPANY _____

GROUP NUMBER _____ INSURANCE CO. PHONE _____

INSURED'S NAME _____ Soc. Security# or ID# _____

PARENT INFORMATION:

FATHER'S NAME _____ BIRTH DATE ___ / ___ / ___

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____

EMPLOYER _____ CITY _____

MOTHER'S NAME _____ BIRTHDATE ___ / ___ / ___

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____

EMPLOYER _____ CITY _____

CHILD'S PRIMARY RESIDENCE: FATHER MOTHER BOTH OTHER (see below)

If OTHER, name of caretaker and address

CONSENT FOR TREATMENT:

I certify that I am the parent/legal guardian of this child who is responsible for medical/dental decisions. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status at future appointments. I authorize Dr. Kimberly Johnson Genc, and/ or Dr. Paul Johnson, and staff to perform the necessary dental services for my child.

Signature _____ Date _____