Demographic Information

Patient_____ Today's Date_____
First MI Last

Name child would like to be called_____ Home Phone_____
Birthday_____Age_____Sex_____ Cell Phone_____
Parent Email: _____ **Text ☐ or Email ☐ appt confirmation OK?**

*Please note for email communication, please review and accept disclosure: ☐ I choose to receive email or text communication as selected and I understand that if information is not relayed in an encrypted manner, there is a risk of it being accessed inappropriately.

Emergency Contact (name & phone) _____

School _____Grade _____

Legal Guardian 1: _____Relation to patient_____DOB_____
Home Address_____
street town state zip code

Employer_____Wk Phone_____

Legal Guardian 2: _____Relation to patient_____DOB_____
Home Address_____
street town state zip code

Employer_____Wk Phone_____

Name of legal guardian accompanying child today_____DOB_____
I give permission to the following people to bring my child to his/her future appointments:_____
_____

Dental Insurance: ☐ Yes ☐ No
Insurance Company_____Group#_____ID#_____
Name of policy holder_____DOB_____SS#_____
Name of child's physician/group_____City/St_____Ph #_____
Names and ages of other children in family_____
Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____

Health History

☐ Yes ☐ No Is your child in good health? Date of last physical exam_____
☐ Yes ☐ No Has your child ever had a health problem?_____
☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_____
_____
☐ Yes ☐ No Is your child allergic to anything?_____
☐ Yes ☐ No Is your child currently taking any medications? Please give medication, dose and reason
_____
_____
☐ Yes ☐ No Were there any problems at birth?_____

Please mark if your child has been treated for any of the following:

☐ AIDS/HIV
☐ Adverse drug reactions
☐ Anemia
☐ Asthma/breathing
☐ Autism
☐ Bleeding/transfusions
☐ Blood dyscrasias
☐ Cancer/tumors
☐ Cerebral palsy
☐ Cleft lip/palate
☐ Congenital birth defects
☐ Diabetes
☐ Down's Syndrome
☐ Endocrine/growth
☐ Eyesight
☐ Frequent infections
☐ Heart disease/murmur
☐ Hepatitis
☐ Kidney disease
☐ Liver/GI disease
☐ Mental delays
☐ MRSA
☐ Personality/social
☐ Physical delays
☐ Reflux/GERD
☐ Rheumatic fever
☐ Seizures
☐ Speech/hearing
☐ Other problems

Do you consider your child to be:

☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

Was your child:

☐ breast fed ☐ bottle fed at what age was it stopped?_____

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last xrays (if taken)_____
Name of dentist and date_____

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care? Explain_____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?_____

☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?

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

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

☐ Cavities	☐ Toothache	☐ Teeth Sensitivity
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

Office Use Only
☐ Fl- City Water
☐ Pvt. Well
☐ Public Well ____ppm
☐ H_2O test kit given

Fluoride History

☐ Yes ☐ No Do you have well water at your home?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

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

Consent for Dental Treatment

I request and authorize Dr. Mark Cummings to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the dentist to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. 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. Mark Cummings will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ **Date** _____