Raleigh Pediatric Dentistry

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Demographic Information

First Name_____MI_____Last_____ Today's Date_____

Name child would like to be called_____Home Phone _____

Birthday_____ Age_____ Sex_____ Cell Phone_____

School_____ Grade _____

Home Address_____

street *town* *zip code*

Parent/Guardian_____E-mail_____

Employer_____Phone_____

Parent/Guardian_____E-mail_____

Employer_____Phone_____

Who has legal custody of patient?_____Dental Insurance: ☐ No ☐ Yes _____

Person responsible for payment of account_____ SS#_____DOB_____

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? Name of child's physician _____

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

☐ Heart disease	☐ Bleeding/transfusions	☐ Asthma/breathing	☐ Blood dyscrasias
☐ Liver/GI disease	☐ Anemia	☐ Diabetes	☐ AIDS/HIV
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Cerebral palsy	☐ Congenital birth defects	☐ Personality/social	☐ Autism
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	☐ Adverse drug rxn
☐ Eyesight	☐ Significant injuries	☐ Endocrine/growth	☐ Other problems

Please elaborate on any items checked:_____

_____

_____

_____

Office use only

-over-

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? 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 Sensitive
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

_____

Fluoride History

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

☐ Yes ☐ No Is your home water supply fluoridated?

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

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

☐ Yes ☐ No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Olson and Associates 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 doctor 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. The doctor 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** _____