

TIMBERLANE DENTAL GROUP

5070 Shelburne Road
Shelburne, VT 05482
Tel. 985-9797

60 Timber Lane
So. Burlington, VT 05403
Tel. 864-6881

87 Main Street
Essex Jct., VT 05452
Tel. 878-8348

1127 No. Avenue, Ste. 1
Burlington, VT 05408
Tel. 862-0770

Pediatric & Adolescent Dentistry

Charles Bookwalter, D.D.S., M.S.
Gary B. Davis, D.D.S., M.S.
Shon C. DiGuglielmo, D.D.S.
Theron J. Main, D.D.S.
George M. Richardson, D.D.S.
Thomas J. Ruescher, D.M.D.

Orthodontics

Thomas J. Fischer, D.M.D., M.S.
Christopher L. Lundberg, D.D.S., M.S.
Fred D. Ziegler, D.M.D.

CHILD'S NAME _____ NICK NAME _____ DATE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____
 AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ SEX _____
 NAME AND AGE OF BROTHERS _____ PATIENT WEIGHT _____
 NAME AND AGE OF SISTERS _____ PATIENT HEIGHT _____
 CHILD'S PHYSICIAN OR PEDIATRICIAN _____ ADDRESS _____
 DATE OF LAST VISIT _____ PHONE NUMBER _____
 FAMILY DENTIST _____
 WHOM MAY WE THANK FOR REFERRING YOU TO US _____
 REASON FOR THIS APPOINTMENT _____
 NAME OF CHILD'S PET AND/OR HOBBY _____
 PARENT'S NAME _____ PARENT'S NAME _____
 PARENT'S D.O.B. _____ PARENT'S D.O.B. _____
 PARENT'S SOC. SEC. # _____ PARENT'S SOC. SEC. # _____
 PARENT EMPLOYED BY _____ WK PHONE _____ HOME PHONE _____ CELL PHONE _____
 PARENT EMPLOYED BY _____ WK PHONE _____ HOME PHONE _____ CELL PHONE _____
 PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____ RELATIONSHIP TO CHILD _____
 WHO HAS LEGAL CUSTODY OF CHILD _____

CHILD MEDICAL HISTORY

1a. IS YOUR CHILD BEING TREATED BY A PHYSICIAN NOW?
 IF YES, EXPLAIN _____

1b. IS YOUR CHILD CURRENTLY TAKING MEDICATIONS?
 IF YES, LIST MED'S AND DOSE _____

2. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR TREATED IN AN EMERGENCY ROOM FOR AN ILLNESS OR SIGNIFICANT INJURY?
 EXPLAIN _____

3. IS THERE ANY ALLERGY TO MEDICATIONS OR ANY ADVERSE DRUG REACTIONS? _____

4. ANY OTHER ALLERGIES: LATEX, FOOD, HAY FEVER, DUST OR OTHER? _____

5. HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT? _____

6. HAS YOUR CHILD EVER RECEIVED A BLOOD TRANSFUSION? _____ IF YES, GIVE DATE _____

7. HAS YOUR CHILD HAD ANY HISTORY OF:

	Y	N		Y	N		Y	N
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES.....	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD OR BLEEDING DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>	CEREBRAL PALSY	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT SORE THROATS, EAR ACHES/OTHER INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	BEHAVIORAL/LEARNING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>
EYE PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	HEART PROBLEMS OR MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS (TB).....	<input type="checkbox"/>	<input type="checkbox"/>	SPEECH OR HEARING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>
BONE OR JOINT PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV (+) / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	BIRTH DEFECTS OR GENETIC DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS.....	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>
LUNG PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	RECURRENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>	INFECTIOUS DISEASES.....	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE (GLAND) PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENTAL DELAYS.....	<input type="checkbox"/>	<input type="checkbox"/>

7. HAS YOUR CHILD HAD ANY CHILDHOOD DISEASES, MUMPS, CHICKEN POX,
 ROSEOLA, MEASLES, OR HAD A HIGH FEVER? (Please underline condition).

8. IS THE PATIENT PREGNANT AT THIS TIME?

(PLEASE FILL OUT REVERSE SIDE.)

DENTAL HISTORY

Y N

- 1. Are you currently on a fluoridated water system or is your child taking a daily fluoride supplement? If supplement, what is the dosage?
2. Has your child had a recent dental problem? What?
3. Give date of last dental care Where? Date of last Dental X-Rays?
4. Do you consider your child high strung or nervous?
5. Has your child had an unfavorable experience at a dental or medical office?
6. How do you think your child will respond to dental care?
7. Any history of injuries to the teeth, face or head
8. Is there any history of headaches, grinding, or TMJ (joint) problems?
9. Does your child have a history of thumb-sucking, nail biting, tongue habits or pacifier? Current Past Until what age? years
10. Was your child bottle-fed? Until what age?
11. Has mother or father had a lot of tooth decay?
12. Is there a family history of dental problems? Please describe
13. Are your child's teeth brushed daily? How often?
14. Do you assist your child with brushing? How often?
15. Are dental floss or disclosing agents used?
16. Is there anything else I should know about your child?
17. Name of dental insurance coverage Group Number If Medicaid, please list number

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY AND/OR ALL NECESSARY DENTAL SERVICE CAN BE STARTED.

AUTHORIZATION IS HEREBY GRANTED. I WILL BE RESPONSIBLE FOR ANY FEE INCURRED FOR TREATING THIS CHILD UNLESS IT IS LEGALLY THE RESPONSIBILITY OF ANOTHER AGENCY.

SIGNED

DATE

Dentist's remarks and summary: