

TIMBERLANE DENTAL GROUP

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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 _____

PARENTS	
NAME	_____
DOB	_____
SSN	_____
HOME PH#	_____
CELL PH #	_____
EMPLOYED BY	_____
WORK PH #	_____
EMAIL	_____

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"/>	CEREBRAL PALSY	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD OR BLEEDING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT SORE THROATS,			BEHAVIORAL/LEARNING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
EAR ACHES/OTHER INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	HEART PROBLEMS OR MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>
EYE PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	SPEECH OR HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	BIRTH DEFECTS OR GENETIC DISORDERS ...	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS (TB)	<input type="checkbox"/>	<input type="checkbox"/>	HIV (+) / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>
BONE OR JOINT PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	INFECTIOUS DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	RECURRENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENTAL DELAYS	<input type="checkbox"/>	<input type="checkbox"/>
LUNG PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	AUTISM	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE (GLAND) PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	SMOKING	<input type="checkbox"/>	<input type="checkbox"/>
						CHEWING TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>
7. HAS YOUR CHILD HAD ANY CHILDHOOD DISEASES: (Please underline condition)
MUMPS, CHICKEN POX, ROSEOLA, MEASLES, OR HAD A HIGH FEVER? _____
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? _____ | ☐ | ☐ |
| 10. | Was your child bottle-fed? _____ Until what age? _____ | | |
| 11. | Was your child nursed? _____ Until what age? _____ | | |
| 12. | Does or did your child use a sippy cup? _____ Until what age? _____ | | |
| 13. | Has mother or father had a lot of tooth decay? | ☐ | ☐ |
| 14. | Is there a family history of dental problems?
Please describe _____ | ☐ | ☐ |
| 15. | Are your child's teeth brushed daily?
How often? _____ | ☐ | ☐ |
| 16. | Do you assist your child with brushing?
How often? _____ | ☐ | ☐ |
| 17. | Are dental floss or disclosing agents used? | ☐ | ☐ |
| 18. | Is there anything else I should know about your child? _____
_____ | | |

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: _____

