Office use: PA _____ BW (NM) 2 / 4 Pan (Y / N) No Fluoride # in fam. _____ #_____

IT'S GREAT SEEING YOU.... WHAT'S NEW?

CHILD'S NAME _____ AGE _____

As always, it's nice having your family in our Pediatric Dental Practice. Our periodic maintenance exam includes: A growth and development assessment of your child's face and jaw; a thorough hard tissue exam (looking for cavities); an intraoral soft tissue exam (gums, cheeks, tongue, etc.); and an oral hygiene evaluation and instruction. X-rays are taken only when needed to complete a proper diagnosis.

PLEASE NOTE: Dental Insurance policies change frequently; therefore we cannot guarantee what your insurance company will pay. For example, as a way to cut their costs, **many policies only pay for one fluoride treatment per calendar year**. Furthermore each policy has different age and treatment limitations. We will estimate your "payment due" at each appointment, but ultimately you are responsible for the entire balance.
Dental Insurance Carrier: _____

It is important for us to know your child's ***current medical status***. So that we may provide your child with the best and safest dental care, please carefully answer the following questions:

Primary concern/reason for today's visit:_____

Has your child had any history of the following, for which he/she has received treatment, medications, or surgery?

- ☐ Seizures
- ☐ Blood disorders
- ☐ Prolonged bleeding
- ☐ Transfusions
- ☐ HIV
- ☐ ADD, ADHD
- ☐ Cerebral Palsy
- ☐ Mental retardation
- ☐ Heart murmur
- ☐ Other heart trouble
- ☐ Diabetes
- ☐ Learning disability
- ☐ Autism/PDD/Asberger's
- ☐ Asthma
- ☐ Kidney or liver disorders
- ☐ Lung or breathing problems
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Hearing loss/speech problems
- ☐ Frequent ear/throat infections
- ☐ Ear tubes
- ☐ Complications from sedation or general anesthesia
- ☐ Other _____
- ☐ **NONE APPLY**

PLEASE ANSWER THE FOLLOWING OR CIRCLE: YES, NO OR NONE

1. List any medications or herbal supplements your child has taken in the last month or takes regularly: _____ or **NONE**
2. Has your child had any unfavorable reaction or allergy to drugs including antibiotics, local anesthetic solutions, iodine, latex, food coloring, or nickel?
   Please Describe _____ or **NONE**
3. Please list any habits (including thumb-sucking, smoking or smokeless tobacco use), dental problems or concerns you would like addressed at this appointment:
   _____or **NONE**
4. Is your child currently in orthodontic treatment? **YES / NO** (Braces)___(Retainer)___.

_____
Home mailing address

_____
City State Zip

_____
Email address

_____
Emergency contact person, relationship

_____
Emergency contact phone number

_____
Home phone number

_____
Work phone (**mother**)

_____
Cell phone (**mother**)

_____
Work phone (**father**)

_____
Cell phone (**father**)

_____ _____
Signature (legal guardian) & relationship to patient ***Date***