All Kids Dental, PC Patient Name:_____ Date of Birth:_____

Dental History

Reason for today's visit: ☐ Check-up ☐ Toothache ☐ Cavities ☐ Injury ☐ Other:_____

Has your child seen a dentist before? _____ Date of last dental exam:_____

Dentist's Name:_____ Date and type of last radiographs: _____

Describe your child's last dental experience:_____

How will your child react to today's visit? ☐ Cooperative ☐ Uncooperative ☐ Unsure

Any history of the following:

☐ Cavities ☐ Toothaches ☐ Dental Injury ☐ Oral Habits ☐ Grinding ☐ Jaw Clicking/Popping/Pain

Fluoride Use: ☐ None ☐ Toothpaste ☐ Mouthwash ☐ Supplemental drops/tablets ☐ Prescription Paste

Home Oral Hygiene: Tooth brushing: ☐ Morning ☐ Night ☐ Daily flossing ☐ Mouthwash

How would you describe your child's diet? ☐ Good ☐ High juice ☐ High milk ☐ High sugar ☐ Grazing

Family Dental History: ☐ Significant cavities ☐ Missing/extra teeth ☐ Orthodontics ☐ Periodontal Disease

Medical History

Name of child's physician:_____ Phone #: _____ Date of last visit:_____

Please list all drugs/medications your child is currently taking:_____

Please list all drugs/medications your child is allergic to:_____

Has your child had any of the following medical problems? If yes, please check any that apply:

☐ Abnormal bleeding	☐ ADD/ADHD	☐ Anemia	☐ Asthma
☐ Cancer	☐ Congenital heart disease	☐ Diabetes	☐ Epilepsy/Seizure Disorder
☐ Heart Murmur	☐ Hearing impairment	☐ Handicap/Disability	☐ Hemophelia
☐ HIV/AIDS	☐ Hospital admission	☐ Kidney problems	☐ Liver problems
☐ Rheumatic Fever	☐ Behavioral Disorders	☐ Developmental Delay	☐ Other

I acknowledge that the above information is correct and hereby authorize and request the performance of dental services for my minor child. I understand that at the first appointment (examination, necessary radiographs, cleaning and fluoride varnish) the doctor will explain any of my child's treatment needs, the various behavior guidance approaches, including the use of nitrous oxide, local anesthetics and management approaches that the doctor feels reasonable, necessary and advisable, as well as the availability of alternate viable modes of treatment, the risks and benefits of each, including no treatment. Financial presentations made at that time are a good faith estimate, and I understand that treatment needs could change depending on the time elapsed from initial exam, and accept full financial responsibility for the dental treatment needs of my child. If my child ever has a change in his/her health or medications, I will inform the doctor at the next appointment without fail.

_____

Signature of Parent/Guardian Date