Carolina Smiles Dentistry

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Demographic Information

Patient____________________Today's Date__________

Name child would like to be called________________Home Phone __________

Birthday________ Age________ Sex________ Cell Phone__________

Home Address______________________________

street *town* *zip code*

Names *and ages* of other children in family____________________

School____________________Grade __________

Parent/Guardian____________________E-mail__________

Employer____________________Phone__________

Parent/Guardian____________________E-mail__________

Employer____________________Phone__________

Who has legal custody of patient?________________Dental Insurance: ☐ __________

Person responsible for payment of account____________SS#__________DOB_____

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

Please elaborate on any items checked:____________________

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Office use only

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
- Δ Fl- City Water
- Δ Pvt. Well
- Δ Public Well_____ppm
- Δ 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 the doctor 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** _______________