Date _____

PATIENT INFORMATION

Patient Name_____ **Nick Name:**_____

Birthday_____ **Age**_____ **Grade:** _____ **Sex:** ☐ **Male** ☐ **Female**

School: _____ **Names & ages of siblings:**_____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Home Address_____

street *city, state* *zip code*

Who has legal custody of patient?_____

Your relationship to patient: ☐ **Mother** ☐ **Father** ☐ **Guardian** **Other:** _____

Your name: _____**Your SS#:**_____**Your Date of Birth:** _____

Whom may we thank for referring you to us?_____

What is the reason for your child's dental visit?_____

EMERGENCY CONTACTS

Name _____ **Relationship** _____ **Phone** _____
Name _____ **Relationship** _____ **Phone** _____

HEALTH HISTORY

☐ **Yes** ☐ **No** **Is your child in good health?** **Date of last physical exam**_____

Name of child's physician _____**Phone** _____

☐ **Yes** ☐ **No** **Has your child ever had a health problem?**_____
☐ **Yes** ☐ **No** **Has your child ever been hospitalized or had surgery?**
Please give reason and dates_____
☐ **Yes** ☐ **No** **Is there excessive bleeding when cut?**
☐ **Yes** ☐ **No** **Is your child allergic to anything? If so, what?** _____
☐ **Yes** ☐ **No** **Is your child currently taking any medications?**
Please give medication and reason_____
☐ **Yes** ☐ **No** **Were there any problems at birth?**_____
☐ **Yes** ☐ **No** **Has your child ever had a heart problem?** _____

Please answer each of the following. Has your child ever had any of the following health problems?

Heart disease ☐Yes ☐No	Bleeding/transfusions ☐Yes ☐No	Asthma ☐Yes ☐No	Blood dyscrasias ☐Yes ☐No
Tuberculosis ☐Yes ☐No	Liver/GI disease ☐Yes ☐No	Anemia ☐Yes ☐No	Diabetes ☐Yes ☐No
AIDS/HIV ☐Yes ☐No	Kidney Disease ☐Yes ☐No	Fainting ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Hepatitis ☐Yes ☐No	Mental delays ☐Yes ☐No	Seizures ☐Yes ☐No	Bladder Difficulties ☐Yes ☐No
Speech/hearing ☐Yes ☐No	Congenital birth defects ☐Yes ☐No	Thyroid Dz ☐Yes ☐No	Cleft lip/palate ☐Yes ☐No
Physical delays ☐Yes ☐No	Recurrent headaches ☐Yes ☐No	Chicken Pox ☐Yes ☐No	Frequent Infections ☐Yes ☐No
Personality/social ☐Yes ☐No	Drug/Alcohol abuse ☐Yes ☐No	Cancer ☐Yes ☐No	Measles/Mumps ☐Yes ☐No
Autism/Asperger ☐Yes ☐No	Cerebral Palsy ☐Yes ☐No	Other problems: _____	

Please elaborate on any items checked:_____

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 had a dental visit?**

Name of dentist and date_____

☐ Yes ☐ No **Has your child experienced any unfavorable reaction from previous dental care?**

Explain_____

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 Does your child primarily drink:

☐ Tap Water ☐ Bottled Water ☐ Fluoridated Bottled Water ☐ Refrigerator Water

☐ Yes ☐ No **Do you have a reverse osmosis water filtration system?**

☐ Yes ☐ No **Does your child use fluoridated toothpaste?**

☐ Yes ☐ No **Do you give your child any other form of fluoride? What?**_____

Please list individuals you give permission to bring your child to appointments and make treatment decisions for your child (must be at least 18 years old).

Name: _____ Name: _____

Name: _____ Name: _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Kelly Hilgers and/or her Associate 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 Drs. Hilgers and/or her Associate 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. Drs. Hilgers and/or her Associate 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.

Parent/Guardian Signature _____ **Date** _____

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