CHILD'S INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE _____

PATIENT'S NAME _____

CHILD'S NAME _____ DATE OF BIRTH _____
(NICKNAME IF ANY)

CHILD'S ADDRESS _____ CHILD'S PHONE _____

HOBBIES, SPORTS AND INTERESTS _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RESIDENCE PHONE _____

RESIDENCE ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ SS # _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE, ☐ YES ☐ NO EXPLAIN _____

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Traumatic injury to mouth or teeth
- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Bad breath
- ☐ Complications from extractions
- ☐ Topical Fluoride Treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits; thumbsucking, fingernail biting, cheek biting, etc.
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Between meal snacks
- ☐ Well balanced diet

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ CHILD'S AGE _____

DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergy to Penicillin
- ☐ Allergies to other drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ Radiation Treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies or Leukemia
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Sinus problems
- ☐ Physical or mental handicap
- ☐ Thyroid disorders
- ☐ Eye disorders
- ☐ Tonsillitis
- ☐ Ulcer or colitis
- ☐ Extreme nervousness or apprehension
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

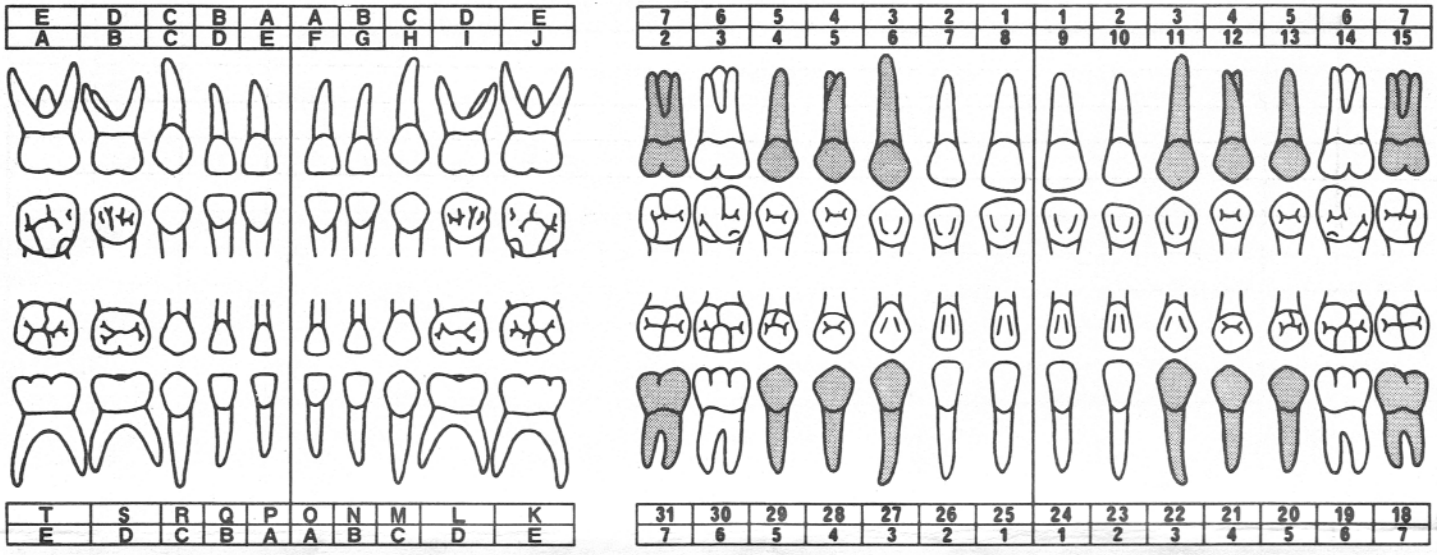
APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____
PARENT OR GUARDIAN

MEDICAL ALERT →

NAME _____ DATE _____ AGE _____



MEDICAL HISTORY SUMMARY

1. EXISTING ILLNESSES _____
2. CURRENT DRUGS _____
3. ALLERGIES _____
4. NUTRITIONAL EVAL. _____

DENTAL HISTORY SUMMARY

1. CHIEF COMPLAINT _____
2. ORAL HABITS _____
3. HYGIENE _____
4. TESTS _____

DENTAL • ORO-FACIAL EXAM

(Circle Abnormalities and Explain)

I. DENTITION

HYPOPLASIA	ANKYLOSIS	SUPERNUMERARY	CROWDING
HYPOCALCIFICATION	CONGENITALLY MISSING	ERUPTION SEQUENCE	OVER-RETENTION
DISCOLORATION/STAINING	SIZE AND SHAPE	PREMATURE LOSS	OTHER _____

II. OCCLUSION AND FUNCTIONAL RELATIONS

ANGLE'S BITE CLASSIFICATION _____

CROSSBITE	OPEN BITE	AXIAL INCLINATIONS	OTHER _____
OVERBITE	MIDLINE DEVIATION	ROTATIONS	_____
OVERJET _____ mm	SPACING AND/OR CONTACTS	ARCH LENGTH	_____

III. GINGIVA AND PERIODONTIUM

PLAQUE	BLEEDING	CALCULUS

IV. SOFT AND HARD TISSUE

FACE	ORO-PHARYNX	SALIVARY GLANDS	LYMPH NODES
LIPS	PALATE	TONGUE	T.M.J.
FLOOR OF MOUTH	CHEEKS	FRENUM	OTHER _____

SUMMARY OF PERTINENT FINDINGS AND RESULTS OF X-RAYS (Excluding Caries)

MEDICAL ALERT →

NAME ____________________

DATE	TOOTH NO.	SERVICES RENDERED	ACCOUNT RECORD		
			CHARGE	PAID	BALANCE

MEDICAL ALERT →

NAME ____________________

DATE	TOOTH NO.	SERVICES RENDERED	ACCOUNT RECORD		
			CHARGE	PAID	BALANCE