PATIENT'S INFORMATION Name _____ Address _____ City _____

State _____ Zip _____ Home Phone _____ Sex _____ Patient Birthdate _____ Referred by _____

Patient's weight _____ lbs _____ kgs Reason for dental visit _____

Pediatrician Name _____ Pediatrician Address _____ Pediatrician Phone _____

MOTHER'S INFORMATION Name _____ Occupation _____ Employer _____ SS# _____

Business Phone _____ Home Phone _____ Cell Phone _____ Email _____ Birthdate _____

FATHER'S INFORMATION Name _____ Occupation _____ Employer _____ SS# _____

Business Phone _____ Home Phone _____ Cell Phone _____ Email _____ Birthdate _____

MEDICAL HISTORY

Has your child ever had any of the following? (Please check YES or NO by each item)
If YES please explain below:

YES	NO		
		1.	Heart Disease/Defect
		2.	Rheumatic Fever
		3.	Hepatitis or Liver Disease
		4.	Diabetes
		5.	Blood Transfusion
		6.	Abnormal Bleeding
		7.	Epilepsy
		8.	Tuberculosis
		9.	Arthritis
		10.	Kidney Disease
		11.	Thyroid Disease
		12.	Hormonal Dysfunction
		13.	Allergies (drugs/medications, food, latex, metals, acrylics, dyes, etc.)
		14.	Hay Fever
		15.	Asthma or Reactive Airway Disease
		16.	Tumor
		17.	Mumps
		18.	Measles
		19.	Chicken Pox
		20.	Pneumonia
		21.	Constant Ear Infections or Chronic Sinusitis
		22.	Anemia
		23.	AIDS or AIDS related complex

Explain: Number, date, and duration _____

Additions: Date _____

	YES	NO
Is this your child's first visit?		
Is your child in good health?		
Does your child have a mental or physical handicap? Explain		
Did your child have a baby bottle at nap and/or bed time? How long?		
Does your child have a finger habit?		
Has your child had an unfavorable reaction to medical/dental treatment?		
Is your child taking any drugs or medicine now? What?		
Does your child have any other medical problem we should know about?		
Are your child's immunization's up to date?		

CONSENT

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any and/or all dental treatment can be started and completed by the doctor Our examination may or may not include dental x-rays, depending on your child's specific needs. Photographs for diagnosis, treatment planning and teaching may be made.

Consent is hereby given for restorative and/or surgical dental treatment. The restorative materials used may include resin fillings, resin sealants, silver fillings and stainless steel crowns. Restorative treatment may include tooth nerve removal when necessary. Surgical treatment may include but not be limited to tooth removal and minor gum problems. Local anesthesia and nitrous oxide and oxygen are used routinely as needed for your child's comfort.

No sedative drugs are used without prior consent by parent. If it becomes necessary due to a cooperation problem to control or relax the patient by the use of sedatives, you will be consulted in advance. Physical restraint is not used without a parent's consent.

I acknowledge that I will be responsible for arranging for payment of any bills incurred on the above child for dental treatment. I understand that all charges are due and payable upon receipt of my monthly statement and all delinquencies are subject to outside collections and that I may be responsible for attorney fees and reasonable collection costs. I also agree to and understand that interest may be assessed on any unpaid balance over thirty (30) days delinquent.

Signature _____ Witness _____

Relationship _____ Date _____