

Habits

Does your child have or had any of the following habits?

- Thumb or finger sucking Y N Did your child use a bottle? Y N Is the bottle used at night? Y N
 Lip sucking or biting Y N If yes, when did he/she stop? _____ If yes, what do you put in the bottle? _____
 Pacifier use Y N
 Biting hard objects Y N Does your child currently use a bottle? Y N Does your child currently nurse? Y N
 Nail biting Y N If yes, how often during the day? _____
 Tooth grinding Y N

Medical History

Check if you has/had any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS / HIV+ | <input type="checkbox"/> Convulsions (seizures) | <input type="checkbox"/> Heart Defect | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Hospital Stays or Operations | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Trauma to mouth or face |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> G-Tube | <input type="checkbox"/> Learning Disabilities
(Dyslexia, Hyperactivity Delayed) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Not up to Date on
Immunizations |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Handicap / Disabilities | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Food Allergies (Fruits,
Dairy, Nuts etc.) |
| <input type="checkbox"/> Continuous Colds | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Craniofacial Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Penicillin Allergy |

Please describe any other medical problems not listed here: _____

MEDICATIONS

List medications you are currently taking:

ALLERGIES

Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Is your child now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Young Women (12 years and older): Is your daughter taking birth control? Yes No

Is your daughter pregnant? Yes No

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent/Guardian Signature: _____ Date: _____

Authorization

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Guardian Signature: _____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.