



The Greensboro Center for Pediatric Dentistry

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PEDIATRIC DENTISTRY

Date _____

Child's Name _____
First Last Nickname _____

Age _____ Date of Birth _____ Sex Male Female

Father's Name _____ Address _____

_____ Phone _____ DOB ___/___/___ SS# _____
City State Zip

Employed By _____ Bus. Phone _____
Name of Business

Present Position _____ How long held _____

Mother's Name _____ Address _____

_____ Phone _____ DOB ___/___/___ SS# _____
City State Zip

Employed By _____ Bus. Phone _____

Present Position _____ How long held _____

Other children in family (and ages) _____

Do you have dental insurance that may cover part of this professional service? Yes _____ No _____

Who may we thank for referring you? _____

DENTAL HISTORY

	YES	NO		YES	NO
What is your main dental concern? _____			Any lost teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			Does your child brush daily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is this your child's first visit to the dentist? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you help your child brush? _____	<input type="checkbox"/>	<input type="checkbox"/>
Who was last dentist? _____			Is dental floss used? _____	<input type="checkbox"/>	<input type="checkbox"/>
Last date teeth cleaned _____			Is fluoride taken in any form? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child complained about dental problems? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have well water? _____	<input type="checkbox"/>	<input type="checkbox"/>
Explain _____			Summary _____		
Any unhappy dental experiences? _____ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Any injuries to mouth, teeth or head? _____ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Any mouth habit --- thumb, pacifier, nail biting, _____ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Bottle, etc.? _____			_____		

MEDICAL HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| Is child under care of physician now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Is child receiving any medication or drugs? (List Below)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| Is there any excessive bleeding when cut?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Has child ever been hospitalized/surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Has child ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any allergy to penicillin or other drugs? (List Below)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| Are there other allergies? (List Below) | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| Does child have good physical coordination? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any emotional issues? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child current on immunizations?..... | <input type="checkbox"/> | <input type="checkbox"/> |

DOES CHILD HAVE ANY HISTORY WITH THE FOLLOWING:

- | | | | |
|--------------------------|--------------------|---------------------|---------------------------|
| ___ ADHD / ADD | ___ Cerebral Palsy | ___ Hearing | ___ Rheumatic Fever |
| ___ Anemia | ___ Chronic Sinus | ___ Heart Murmurs | ___ Thyroid |
| ___ Anxiety / Depression | ___ Convulsions | ___ Kidney | ___ Tuberculosis |
| ___ Asthma | ___ Diabetes | ___ Liver/Hepatitis | ___ HIV/AIDS |
| ___ Autism | ___ Down Syndrome | ___ Malignancies | ___ Other/Please indicate |
| ___ Bladder | ___ Epilepsy | ___ Mononucleosis | _____ |

Summary _____

PERMIT FOR TREATMENT UPON A MINOR

Child's Name _____ Age _____

I, being the parent or guardian of the above minor patient, do hereby authorize and request the performance of dental services for this patient; and further, the performance of whatever procedures the judgment of the above named doctors may deem necessary during the performance of any dental treatment.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by the doctor, with my knowledge.

Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment. I also understand that payment for treatment rendered is expected at the end of each appointment, unless other financial arrangements are made.

Parent/Guardian Signature _____ Date _____