

CHILDS NAME _____ AGE: ____ D.O.B. _____
 NICKNAME _____
 MOTHER'S NAME _____
 FATHER'S NAME _____
 LEGAL GUARDIAN(IF OTHER THAN PARENT) _____
 RESIDES WITH: ()MOTHER ()FATHER ()BOTH ()OTHER _____
 PHYSICIAN'S NAME _____ PHONE # _____
 CHILDS INTERESTS OR HOBBIES _____
 LAST VISIT TO DENTIST _____
 EMERGENCY CONTACT: _____ PHONE # _____

**MARK WITH "X" IF ANY OF THESE DID OR DOES
PERTAIN TO YOUR CHILD**

- | | |
|---|--|
| <input type="checkbox"/> BIRTH DEFECTS | <input type="checkbox"/> HIV OR HEPATITIS |
| <input type="checkbox"/> HANDICAPPED | <input type="checkbox"/> HOSPITALIZED |
| <input type="checkbox"/> LEARNING DISABILITY | WHEN _____ WHY _____ |
| <input type="checkbox"/> SPECIAL EDUCATION | <input type="checkbox"/> TONSIL/ADENOID REMOVAL |
| <input type="checkbox"/> SPEECH THERAPY | <input type="checkbox"/> REACTION TO ANESTHESIA |
| <input type="checkbox"/> OT/PT | <input type="checkbox"/> FREQ. CANKER/COLD SORES |
| <input type="checkbox"/> HYPERACTIVITY/ADHD/ADD | <input type="checkbox"/> HISTORY OF BLOWS TO TEETH |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> HABITS ABOUT THE MOUTH |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> THUMB SUCKING HABITS |
| <input type="checkbox"/> ENVIROMENTAL ALLERGIES | <input type="checkbox"/> USE OF PACIFER |
| <input type="checkbox"/> DRUG ALLERGIES(list below) | <input type="checkbox"/> GAGS OR THROWS UP EASILY |
| <input type="checkbox"/> REACTION TO NOVOCAINE | <input type="checkbox"/> COMPLAINS ABOUT TEETH |
| <input type="checkbox"/> UPPER RESPIRTORY INFECTIONS | <input type="checkbox"/> GUM-BOILS |
| <input type="checkbox"/> TUBES IN EARS | <input type="checkbox"/> FALLS ASLEEP WITH BOTTLE |
| <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> HAS FLUORIDATED WATER |
| <input type="checkbox"/> FREQ TONSILLITIS/SORE THROAT | <input type="checkbox"/> TAKING FLUORIDE TABLETS |
| <input type="checkbox"/> MOUTH -BREATHES | <input type="checkbox"/> CURRENT TREATMENT BY DR. |
| <input type="checkbox"/> BLEEDING PROBLEMS | <input type="checkbox"/> UPSETS OVER NEEDLES |
| <input type="checkbox"/> HEART DISORDER OR MURMUR | <input type="checkbox"/> EASILY CRIES WHEN |
| <input type="checkbox"/> RHEUMATIC FEVER | UPSET OR HURT |

DRUG ALLERGIES _____

PLEASE LIST DAILY MEDICATIONS AND REASON FOR TAKING:

PARENTAL CONSENT FOR EXAMINATION OR ORIENTATION:

I HEREBY GIVE MY CONSENT FOR A THOROUGH ORAL EXAMINATION OF MY CHILD, INCLUDING THE TAKING OF ANY AGREED UPON NECESSARY X-RAYS AND PHOTOS. THESE PHOTOS AND X-RAYS WILL BE USED EXCLUSIVELY FOR IDENTIFICATION AND DIAGNOSTIC PURPOSES. IF NEEDED THESE MAY ALSO BE SHARED WITH OTHER MEDICAL PROFESSIONALS. I UNDERSTAND THAT ANY NEEDED CORRECTIVE TREATMENT WILL BE EXPLAINED AND AGREED TO PRIOR TO BEGINNING SUCH TREATMENT.

_____ (SIGNATURE) _____ (RELATIONSHIP) _____ (DATE)