Habits

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

Thumb or finger sucking ❑ Y ❑ N
Lip sucking or biting ❑ Y ❑ N
Pacifier use ❑ Y ❑ N
Biting hard objects ❑ Y ❑ N
Nail biting ❑ Y ❑ N
Tooth grinding ❑ Y ❑ N

Did your child use a bottle? ❑ Y ❑ N
If yes, when did he/she stop? ____________

Does your child currently use a bottle? ❑ Y ❑ N
If yes, how often during the day? _______

Is the bottle used at night? ❑ Y ❑ N
If yes, what do you put in the bottle? ______

Does your child currently nurse? ❑ Y ❑ N

Medical History

Check if you has/had any of the following:

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