Charles W. Roberts, DDS Pediatric Dentistry

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Demographic Information

Patient____ Date_____________________

Name child would like to be called____

Birthday__________ Age_________ Sex______________ Home Phone_______________

Home Address____

street *town* *zip code*

Names *and ages* of other children in family_______________________________________

School____ Grade ___________________

Mother___________________Cell #_______________E-mail________________________

Mother's Employer___________________________________Phone____________________

Father____________________Cell #________________E-mail________________________

Father's Employer____________________________________Phone____________________

Who has legal custody of patient?____

Person responsible for payment of account________________ SS#___________DOB______

Dental Insurance: Yes No **If Yes, please complete insurance plan profile sheet**

Whom may we thank for referring you to us?____

What is the reason for your child's dental visit?______________________________________

Health History

Yes No Is your child in good health? Name of child's physician ________________

Date of last physical exam______________

Yes No Has your child ever had a health problem?_______________________________

Yes No Has your child ever been hospitalized? Please give reason and dates_______

____

Yes No Is your child allergic to anything?_____________________________________

Yes No Is your child currently taking any medications? Please give medication and reason____

Yes No Were there any problems at birth?_____________________________________

Please check if your child has been treated for any of the following:

Heart disease	Bleeding/transfusions	Asthma	Blood dyscrasias
Liver/GI disease	Anemia	Diabetes	AIDS/HIV
Kidney disease	Rheumatic fever	Hepatitis	Mental delays
Speech/hearing	Seizures	Cleft lip/palate	Physical delays
Cerebral palsy	Congenital birth defects	Personality/social	**Other problems**
Cancer/tumors	Recurrent headaches	Frequent infections	

Please elaborate on any items checked:____

____

-over-

Do you consider your child to be: advanced in the learning process
progressing normally
slow in the learning process

Was your child: breast fed bottle fedAt what age was it stopped?________

Dental History

Yes No Has your child ever been to the dentist? Name of dentist and date________
____

Yes No Has your child experienced any unfavorable reaction from previous dental care? Explain____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

Cavities	Toothache	Teeth Sensitive
Trauma	Gum Infections	Color of teeth
Orthodontics	Jaw Sounds	Other

Comments: ____
____

Fluoride History

Office Use Only
☐ Fl- City Water
☐ Pvt. Well
☐ Public Well _____ppm
☐ H_2O test kit given

Yes No Is your home water supply fluoridated?

Yes No Does your child use a fluoride toothpaste?

Yes No Do you give your child any other form of fluoride? What?________________

Yes No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Roberts to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Roberts to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Roberts will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature ____ **Date** ________________

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