



CHILD'S NAME _____ NICKNAME _____

DATE OF BIRTH ___/___/___ AGE _____ WEIGHT _____ lbs. MALE ___ FEMALE ___

SCHOOL OR DAYCARE NAME _____

NAME OF SIBLINGS _____

NAME OF PET, FRIEND _____

SPORTS OR ACTIVITIES _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DENTAL HISTORY:

PURPOSE OF TODAY'S VISIT _____

DATE OF LAST EXAM _____ LAST X-RAYS _____

ANY UNFAVORABLE DENTAL EXPERIENCES? _____

NAME OF PREVIOUS DENTIST _____

PLEASE (X) ANY WHICH APPLY TO YOUR CHILD:

_____ INJURY TO MOUTH OR TEETH Explain _____

_____ ORAL HABITS: Thumb/Finger sucking ___ Pacifier ___ Nail biting ___ Tongue thrust ___

_____ SENSITIVE/ PAINFUL TEETH Explain _____

_____ GRINDING OF TEETH: Daytime ___ Nighttime ___

_____ CHILD STILL NURSING? Breast ___ Bottle ___

FREQUENCY OF BRUSHING _____ Times per day DOES PARENT HELP? Yes ___ No ___

MEDICAL HISTORY:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS? Circle One: Y=Yes, N=No

- | | |
|---------------------------------|---------------------------------|
| Y N HEART MURMUR | Y N RHEUMATIC FEVER/ HIGH FEVER |
| Y N CONGENITAL HEART DEFECT | Y N CANCER/ TUMORS |
| Y N DIABETES | Y N KIDNEY/ LIVER DISEASE |
| Y N HIV VIRUS/ AIDS | Y N MENTAL HANDICAP |
| Y N BLOOD DISORDER/TRANSFUSIONS | Y N PHYSICAL HANDICAP |
| Y N SICKLE CELL ANEMIA | Y N HEARING/SPEECH IMPAIRMENT |
| Y N HEPATITIS/ JAUNDICE | Y N ANXIETY |
| Y N TUBERCULOSIS | Y N HYPERACTIVE/ ADHD/ ADD |
| Y N CONVULSIONS/EPILEPSY | Y N SENSORY DISORDER |
| Y N ASTHMA | Y N AUTISM |
| Y N SINUS/ ALLERGY PROBLEMS | Y N SURGERY |
| Y N PREMATURE BIRTH _____ weeks | Y N HOSPITALIZATION |

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE OR OTHER PROBLEMS NOT LISTED: _____

MEDICATIONS THE CHILD IS TAKING NOW? _____

MEDICATIONS / FOOD THE CHILD IS ALLERGIC TO? _____

CHILD'S PHYSICIAN _____ PHONE _____

PHYSICIAN'S ADDRESS _____ DATE OF LAST EXAM _____

FAMILY ORTHODONTIST'S NAME _____ CITY _____

HAS YOUR CHILD SEEN THE ORTHODONTIST? Yes No LAST EXAM _____

FAMILY MEMBERS WHO SEE THE ORTHODONTIST _____

EMERGENCY CONTACT (Relative or Friend not living with you) NAME _____

RELATIONSHIP TO PARENT? _____ PHONE _____

DENTAL INSURANCE INFORMATION:

DENTAL INSURANCE COMPANY _____

GROUP NUMBER _____ INSURANCE COMPANY PHONE _____

INSURED'S NAME _____ Soc. Security or ID NUMBER _____

PARENT INFORMATION:

FATHER'S NAME _____ Driver's Lic # _____ BIRTH DATE ___/___/___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____ Work Phone _____

Employer _____ City _____ State _____

MOTHER'S NAME _____ Driver's Lic # _____ BIRTH DATE ___/___/___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____ Work Phone _____

Employer _____ City _____ State _____

Family email address: _____

CHILD'S PRIMARY RESIDENCE: FATHER MOTHER BOTH OTHER (See below)

If OTHER, name of caretaker and address _____

CONSENT FOR TREATMENT:

I certify that I am the parent/legal guardian of this child who is responsible for medical/dental decisions. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status at future appointments. I authorize Dr. Hunter and staff to perform the necessary dental services for my child.

Signature _____ Date _____