HOMETOWN FAMILY DENTAL

CREATING SMILES WITH A PERSONAL TOUCH

CHILD PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____Preferred Name: _____ Date of Birth___/___/____

Street Address: _____City: _____State: ____ Zip: _____
Home Phone: _____ Age: _____ Sex: □ Male □ Female
School Currently Attending: _____Grade Level: _____

PARENT INFORMATION

Parent/Legal Guardian: _____ Relation to patient: _____
Employer: _____ Work #: _____ Mobile #: _____Date of Birth ___/___/____
Parent/Legal Guardian: _____ Relation to patient: _____
Employer: _____ Work #: _____ Mobile #: _____Date of Birth ___/___/____
Guardian's Email: _____
Who has legal custody? _____ Dental Insurance □ Yes □ No
Person responsible for payment of account _____ SSN#: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____Work Phone: _____ Mobile: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone#: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Preferred Pharmacy:_____

DENTAL HISTORY

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

□ Yes □ No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
Name of previous dentist: _____Phone: _____

□ 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 go to bed with a bottle or sippy cup?

□ Yes □ No Does your child snack frequently? What are their favorite snack foods? _____

□ Yes □ No Has your child had local anesthetic? Were there any problems? _____

□ Yes □ No Has your child been sedated for dental treatment? Were there any problems? _____

□ Yes □ No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

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

□ Cavities	□ Toothache	□ Sensitive Teeth	□ Mouth Breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Orthodontics	□ Jaw Sounds	□ Grinding of Teeth	

Comments: _____

FLUORIDE HISTORY

What is your home water source: □ City □ Well

□ Yes □ No Does your child use a fluoride toothpaste?

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641-932-2729

□ Yes □ No Do you give your child any other forms of fluoride? What? _____

MEDICAL HISTORY

□ Yes □ No Is your child in good health? Date of last physical exam _____
□ Yes □ No Has your child ever had a health problem? _____
□ Yes □ No Is your child allergic to anything? _____
□ Yes □ No Is your child currently taking any medications? Please give medication, dose, and reason: _____
_____
□ Yes □ No Are your child's immunizations current?
□ Yes □ No Have you travelled to: Liberia, Sierra Leone or Guinea in the last 21 days?
If yes, please let us know when you arrived into the U.S.? Month _____ Day_____
□ Yes □ No Are you feeling feverish?
□ Yes □ No Have you ever been told that your child needs to take *antibiotics before dental treatment*?
□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:
_____
□ Yes □ No Were there any difficulties at birth? _____

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

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

□ Abuse	□ Cancer/tumors	□ Heart murmur	□ Rheumatic fever
□ ADD/ADHD	□ Cerebral palsy	□ Hepatitis	□ Seizures
□ AIDS	□ Cleft lip/palate	□ Kidney disease	□ Sickle cell disease/trait
□ Anemia	□ Congenital birth defects	□ Liver/GI disease	□ Significant injuries
□ Anxiety disorder	□ Diabetes	□ Mental delays	□ Snoring
□ Arthritis	□ Endocrine/growth	□ Personality/social disorder	□ Speech/hearing
□ Asthma/breathing	□ Eyesight	□ Physical delays	□ Spina bifida
□ Autism	□ Frequent infections	□ Recurrent headaches	□ Tonsil/adenoid problems
□ Bleeding/transfusions	□ Heart Disease	□ Recurrent herpes/fever blisters**	□ Tuberculosis
□ Blood dyscrasias			

Please note that if your child has an **active herpes lip lesion on the day of your scheduled appointment, we will ask you to reschedule.

Other: _____
If any boxes checked, please describe further:_____
_____

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Dr. Molly Mullen and her staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Mullen 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 understand the treatment in terms appropriate for their age. Dr. Mullen will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Hometown Family Dental of any changes in my child's medical status.

Legal Guardian's Signature: _____ Date:_____

Doctor Signature: _____ Date:_____

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