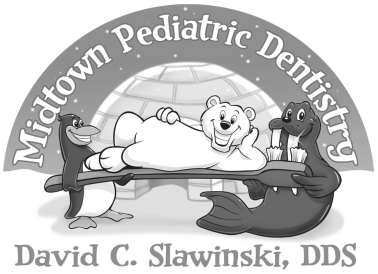

Child's Demographic Information

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____ Age _____ Date of Birth ____/____/_____ Sex M F

Home Address _____ City _____ State _____ Zip _____

Names/ages of siblings _____ _____

What is the reason for today's visit? _____

Whom may we thank for referring you to us? _____

Parent Demographic Information

Mother's Name _____ Mother's Date of Birth ___/___/_____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Employer _____

Father's Name _____ Father's Date of Birth ___/___/_____

Home Phone_____ Cell phone _____ Work Phone _____

Email _____ Employer _____

Person responsible for payment of account _____SS# _____

Child lives with: Both parents Mother Father Other_____ Who has legal custody? _____

Health History

Child's Physician _____ Date of last exam ___/___/_____

Yes No Is your child in good health?

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? _____ Latex Allergy Yes No

Yes No Is your child currently taking any medications? Please give medication, dose and reason:

_____

Yes No Were there any problems at birth? _____

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

Heart disease	Bleeding/transfusions	Asthma/breathing	Blood dyscrasias
Liver/GI disease	Anemia	Diabetes	Adverse drug reactions
Kidney disease	Rheumatic fever	Hepatitis	Mental delays
Speech/hearing	Seizures	Cleft lip/palate	Physical delays
Eyesight	Congenital birth defects	Personality/social	Cancer/tumors

Please Elaborate on any items circled : _____

_____

- Please continue to the back -

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? _____

Please 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? _____

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

Cavities	Toothache	Sensitive teeth
Trauma	Gum infections	Color of teeth
Orthodontics	Jaw sounds	Other

Comments/Concerns: _____

_____

Fluoride History

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? _____

Consent for Dental Treatment

I request and authorize Dr. Slawinski 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. Slawinski 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. Slawinski will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments.

Signature _____ Date _____