Midtown Pediatric Dentistry
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Demographic Information

Patient_____ Date_____
Name child would like to be called_____ Cell Phone_____
Birthday_____ Age_____ Sex_____ Home Phone_____
Home Address_____
street *town* *state* *zip code*
Names *and ages* of other children in family_____
School_____ Grade_____
Mother _____ DOB _____ Email _____
Mother's Employer_____ W Phone_____
Father _____ DOB _____ Email _____
Father's Employer_____ W Phone_____
Who has legal custody of patient?_____
Person responsible for payment of account_____ SS#_____DOB_____
Dental Insurance : ☐ Yes ☐ No
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_____
☐ Yes ☐ No 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?_____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	☐ AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Eyesight	☐ Congenital birth defects	☐ Personality/social	☐ Other problems
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	☐ Adverse Drug reactions
☐ Cerebral palsy	☐ Significant injuries	☐ Endocrine/growth	☐ Autism

Please elaborate on any items circled:_____
_____
_____
_____

-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 fed At 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	☐ Sensitive Teeth
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments _____

_____

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

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?_____

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

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, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ **Date** _____