

PEDIATRIC DENTAL ACQUAINTANCE FORM

Date _____

Demographic Information

Patient's Name _____ Name they would like to be called _____

Age _____ Birth date _____ Social Security Number _____ Sex (Circle one) F M

Address _____
(Street) (City) (State) (Zip Code)

Home Phone Number _____ Names & ages of siblings _____

Mother's Name _____ Social Security # _____

Mother's Employer _____ Work Phone # _____ Mobile Phone # _____

Father's Name _____ Social Security # _____

Father's Employer _____ Work Phone # _____ Mobile Phone # _____

Who has legal custody of patient? _____ Patient lives with: Mother Father Both Other _____

Child's Physician _____ Phone # _____ Date of last exam _____

How did you hear about our office: Internet/Website Friend _____ Physician/Dentist _____ Other _____

What is the reason for today's visit? _____

Please provide your email address if you would like to receive your appointment confirmations by email.

Email Address: _____ (Mother / Father / Other _____)

Health History

YES NO

___ ___ Has your child ever had a health problem? Please explain _____

___ ___ Has your child ever been hospitalized? Please give reason and dates _____

___ ___ Is your child allergic to anything? _____

___ ___ Is your child currently taking any medications? Please give medication and reason _____

___ ___ Were there any problems at birth? _____

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

___ Heart disease	___ Liver disease	___ Kidney disease	___ Bleeding/transfusion
___ Asthma	___ Anemia	___ Rheumatic fever	___ Seizures
___ Diabetes	___ Hepatitis	___ Cerebral palsy	___ Cleft lip/palate
___ AIDS	___ Depression	___ ADHD/ADD	___ Learning Disability
___ Speech/hearing	___ Other Problems (Please explain) _____		

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

Was your child breast fed? (Circle one) Yes / No

At what age was it stopped? _____

Was your child bottle fed? (Circle one) Yes / No

At what age was it stopped? _____

Dental History

YES NO

___ ___ Has your child ever been seen by a dentist? Name of dentist _____
Date of last visit _____ Dentist's phone number _____
___ ___ Has your child experienced any unfavorable reaction from previous dental care?
If yes, please explain _____
___ ___ Does your child suck a: thumb finger(s) pacifier other _____
___ ___ Does your child have pain with chewing, yawning or wide opening? _____
___ ___ 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 are sensitive ___ Color of teeth
___ Trauma ___ Gum infections ___ Orthodontics ___ Other _____

Fluoride History

YES NO

___ ___ Is your drinking water fluoridated? (Your water is fluoridated if you pay a "City of Durham" or "OWASA" water bill.)
___ ___ Do you use well water in your home? If yes, has it been analyzed for fluoride? (Circle one) Yes / No
___ ___ Does your child use a fluoride toothpaste?
___ ___ Do you give your child any other form of fluoride? What? _____

Consent of Dental Treatment

I request and authorize Dr. Christensen 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. Christensen 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 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. Christensen 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.

Signature _____ Relationship to patient _____ Date _____

Payment Policy

I will be responsible for any charges incurred on this child for dental treatment. I understand that by failing to make payments to Dr. Christensen my account can be turned over to a collection agency. Dr. Christensen will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature _____ Relationship to patient _____ Date _____

Growing healthy smiles!