

## PATIENT ACQUAINTANCE INFORMATION

### PATIENT INFORMATION

Child's Full Name		Preferred Name (Nickname)		
Date of Birth	Child's SS#	Age	Gender	Weight
What school does your child presently attend?				
What other children in your family have we seen?				
What is the purpose of this visit?				

Whom may we thank for referring you to our practice? \_\_\_\_\_

### DENTAL HISTORY

Is this your child's first visit to the dentist?	YES ___ NO ___
If not, please share with us why you wish to make a change _____	
If your child has had previous dental visits, how did he/she respond? _____	
Date of last dental exam _____ Date of last dental x-rays _____	
Does your child have a previous history of any oral habits (Mouth breathing, Pacifier, Thumb sucking, Etc.)	YES ___ NO ___
Has your child had any injuries to the mouth or teeth?	YES ___ NO ___
Has your child had a toothache now or recently?	YES ___ NO ___

### MEDICAL HISTORY

Is your child in good general health?	YES ___ NO ___
Is your child currently taking any prescription medication(s)?	YES ___ NO ___
If so, please explain: _____	
Is your child currently taking any over-the-counter medications, herbs, or supplements?	YES ___ NO ___
If so, please explain: _____	
Does your child have any known physical or medical condition(s)?	YES ___ NO ___
If so, please explain: _____	
Has your child experienced any unfavorable reaction to any medication(s)?	YES ___ NO ___
If so, please explain: _____	
Are there any learning, speech, or hearing disorders that may affect the treatment of your child?	YES ___ NO ___

**Pediatrician (Physician)** \_\_\_\_\_ **Date of Last Exam** \_\_\_\_\_

Please indicate with a (✓) any condition(s) your child has or has had:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Allergy to penicillin      | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Other Drug Allergies       | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sickle Cell    | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Hospitalizations/Surgeries | <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> AIDS/HIV       | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> Epilepsy/Convulsions       | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Eye Disorders  | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> Hepatitis/Jaundice         | <input type="checkbox"/> Blood Disorders  | <input type="checkbox"/> Prosthesis     | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Allergies/Hay Fever        | <input type="checkbox"/> Chemotherapy     | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> None of the above |

Please explain any (✓) above and/or note any special information about your child: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

Mother's Full Name			Preferred Name	
Home Address		City	State	Zip code
Phones: Home	Work		Mobile	
Occupation		Employer		How Long?
Social Security#	Date of Birth	Mother's Dentist		

Father's Full Name			Preferred Name	
Home Address		City	State	Zip code
Phones: Home	Work		Mobile	
Occupation		Employer		How Long?
Social Security#	Date of Birth	Father's Dentist		

Child's parents are: \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Not Married  
 If the parents do not live together, with whom does the child live? \_\_\_\_\_

**CARE OF PATIENTS**

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and we will attempt to provide him/her a satisfying experience in our office.

The payment of fees for professional services provided is expected at the time of treatment by the parent or guardian in attendance.

**CONSENT FOR TREATMENT OF A MINOR**

The undersigned hereby states that he/she is the parent/guardian and authorizes Dr. Plunk and/or his staff to perform the examination including x-rays, and after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. The undersigned also grants permission for Dr. Plunk and/or his staff to communicate with other healthcare providers as needed for the appropriate dental care of this child. This consent shall remain in full force and effect until cancelled by either party.

NAME (Print): \_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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Member:  
 American Academy of Pediatric Dentistry &  
 American Association of Orthodontists