Charles W. Roberts, DDS   Pediatric Dentistry

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Demographic Information

Patient_____ Date_____

Name child would like to be called_____

Birthday_____ Age_____ Sex_____ Home Phone_____

Home Address_____
                          street   *town*   *zip code*

Names *and ages* of other children in family_____

School_____ Grade _____

Mother_____Cell #_____E-mail_____

Mother's Employer_____Phone_____

Father_____Cell #_____E-mail_____

Father's Employer_____Phone_____

Who has legal custody of patient?_____

Person responsible for payment of account_____ SS#_____DOB_____

Dental Insurance: Yes   No **If Yes, please complete insurance plan profile sheet**

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 _____
			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?_____	
Yes	No	Is your child currently taking any medications? Please give medication and	
		reason_____	
Yes	No	Were there any problems at birth?_____	

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

Heart disease	Bleeding/transfusions	Asthma	Blood dyscrasias
Liver/GI disease	Anemia	Diabetes	AIDS/HIV
Kidney disease	Rheumatic fever	Hepatitis	Mental delays
Speech/hearing	Seizures	Cleft lip/palate	Physical delays
Cerebral palsy	Congenital birth defects	Personality/social	**Other problems**
Cancer/tumors	Recurrent headaches	Frequent infections	

Please elaborate on any items checked:_____

_____

-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 fedAt 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	Teeth Sensitive
Trauma	Gum Infections	Color of teeth
Orthodontics	Jaw Sounds	Other

Comments: _____
_____

Fluoride History

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Yes	No	Is your home water supply fluoridated?	☐ Fl- City Water
			☐ Pvt. Well
Yes	No	Does your child use a fluoride toothpaste?	☐ Public Well _____ppm
			☐ H_2O test kit given
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. Roberts 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. Roberts 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. Roberts 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 _____

Payment is due in full at time of treatment unless prior arrangements have been approved.