**Patient Information**

Child's Name_____________________________________________________ Date____________________________________

Fathers Name____________________________________________________ Father Cell________________________________

Mothers Name___________________________________________________ Mother Cell________________________________

Home Address___________________________________________________ Home Phone________________________________

Email ___________________________________

City____________________________________ State__________________ Zip code___________________________________

Sex [ ] M [ ] F Age_____________ Birth date______________________Nickname___________________________________

Names and Ages of Brothers and Sisters_____________________________________________________________________

Hobbies, Pets, Favorite TV shows, etc. ______________________________________________________________________

Person Responsible for this account _______________________________________________________________________

Whom may we thank for referring you? _____________________________________________________________________

**DENTAL HISTORY**

Reason for this visit (1st examination, checkup, toothache, etc.) _________________________________________________

Has your child ever had an injury to the mouth, teeth or jaws (fall, blow, etc) ______________________________________

How long since child's last visit to the dentist? ______________________________________________________________

Was the dental experience pleasant or unpleasant? ___________________________________________________________

If unpleasant, how did he/she react? ______________________________________________________________________

Has your child had Novocain? No [ ] Yes [ ] Has your child had laughing gas? No [ ] Yes [ ]

Does your child have any history of thumb or lip sucking, pacifier, nail or lip biting?

If yes, please explain

__________________________________________________________________________________________________

Does your child use fluoride toothpaste? No [ ] Yes [ ]

Has your child ever taken fluoride supplements or vitamins with fluoride? _________________________________________

**MEDICAL HISTORY**

Child's physician/pediatrician ______________________________________ Phone ___________________________________

Address _________________________________________________ City___________ State __________ Zip code ______________

Is your child in good health? ______________________________ Is your child taking any medications? _______________________

Is your child allergic to any medications? __________________________ General allergies? ________________________________

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|---|---|---|
| Any history of cerebral palsy, seizures, fainting, or loss of consciousness? | No [ ] | Yes [ ] |
| Any sensory disorders, ADHD or autism? | No [ ] | Yes [ ] |
| Any congenital heart disease, heart murmur or rheumatic fever? | No [ ] | Yes [ ] |
| Has any heart surgery been done or recommended? | No [ ] | Yes [ ] |
| Has your child ever had a blood transfusion? | No [ ] | Yes [ ] |
| Any history of anemia or sickle cell disease? | No [ ] | Yes [ ] |
| Does your child bruise easily or bleed excessively from small cuts? | No [ ] | Yes [ ] |
| Any history of pneumonia, cystic fibrosis, asthma, or difficulty breathing? | No [ ] | Yes [ ] |
| Any history of stomach, intestinal, kidney or liver problems? | No [ ] | Yes [ ] |
| Any history of hepatitis? | No [ ] | Yes [ ] |
| Any history of diabetes? | No [ ] | Yes [ ] |
| Any history of thyroid disease or other glandular disorders? | No [ ] | Yes [ ] |
| Has your child ever been hospitalized? | No [ ] | Yes [ ] |

(If yes, please explain) ________________________________________________________________________________

Any additional or related problem? ________________________________________________________________________________

## CONSENT

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor for a thorough diagnosis of the patient's dental needs.

2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ____________________________________.

3. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of dental insurance coverage, I am responsible for payment of services rendered.

4. I understand that Dr. Simonis sets aside dedicated time in her office for my child's dental appointment. If I find it necessary to cancel, I will provide a 24 hour advanced notice. Without proper notice I understand there will be a $75.00 fee.

5. **Payment for professional services is due at the time of treatment. For your convenience, we accept all major credit cards, cash and checks, as we do not participate with any insurance companies.**

Signature__________________________________________Relationship____________________ Date ________________