Welcome

Today's Date: ________________

TELL US ABOUT YOUR CHILD

Child's Name (First/Middle/Last) ______________________

Nickname ______________________ M _____ F _____

Birthdate ___/___/___ Child's Age _______ School _______________

Child's Home Street Address ______________________

Child's Home Phone # (_______) ______________________

City _____________ State _______ Zip _______

Do you have legal custody of child? Yes _____ No _____

Is your child adopted? Yes _____ No _____

Whom may we thank for referring you? ______________________

Other family members seen here ______________________

Who does the child live with? ____

PARENT/GUARDIAN INFORMATION

Parents' Marital Status:

Single _______ Married _______ Divorced _______ Separated _______ Widowed _______ Domestic Partners _______

Please complete both sections, one for each parent/guardian.

Name ______________________

Relationship to Child ______________________ M _____ F _____

Birthdate ____/____/____ SSN ____-____-____

Home Phone # (_____) ____________ Cell Phone # (_____) ____________

Employer ______________________

Work Phone # (_____) ____________ Occupation ____________

Email ______________________

☐ Check here if address is same as child's, OR indicate below

Address ______________________

____

Name ______________________

Relationship to Child ______________________ M _____ F _____

Birthdate ____/____/____ SSN ____-____-____

Home Phone # (_____) ____________ Cell Phone # (_____) ____________

Employer ______________________

Work Phone # (_____) ____________ Occupation ____________

Email ______________________

☐ Check here if address is same as child's, OR indicate below

Address ______________________

____

The following individuals (Name/Relationship) can accompany my child to Canton Pediatric Dentistry for any preventive and/or restorative treatment appointments for services as recommended by Dr. Sam Malcheff and/or his associates. This consent will be effective until rescinded, in writing. ______________________________

____

____

Child's Name__________________________ **Reason for today's visit**__________________________________

DENTAL HISTORY

Is this your child's first visit to a dentist? Yes___No___

If no, who was the previous dentist?

____

Date of last dental visit________________________

Were any x-rays taken when your child previously visited the dentist? Yes____No____

Has your child ever had a problem associated with dental treatment? Yes____No____

Has your child ever had any pain in his/her mouth or jaw? Yes____No____

Has your child ever had any trauma to his/her head or neck? Yes____No____

Does your child brush teeth daily? Yes____No____

Do you assist in brushing? Yes____No____

Does your child floss daily? Yes____No____

Do you assist in flossing? Yes____No____

Does your child have any oral habits? (thumb/finger/pacifier, nail biting, etc.) Yes____No____

DIET HISTORY

Does/did your child:

Breast-feed? Yes____No___ Age when stopped______

Bottle feed? Yes____No___ Age when stopped______

Snack more than twice a day? Yes__No__

What does your child drink with meals?______________

____

What does your child drink between meals?__________

____

Does your child have dietary restrictions? Yes__No__

Does your child have an eating disorder? Yes__No__

Does your child chew gum? Yes__No__

Does your child take fluoride supplements? Yes__No__

Water: City___Well___Reverse Osmosis___Bottled___

If bottled, does it contain fluoride? Yes__No__

MEDICAL HISTORY

Please check any of the following that your child has had or presently has:

- ☐ ADD/ADHD
- ☐ Allergies - Seasonal/Environmental
- ☐ Allergies - Food
- ☐ Arthritis
- ☐ Artificial Joint/Valve
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Emotional Disturbance
- ☐ GERD/Reflux Disease
- ☐ Hearing Impairment
- ☐ Hepatitis/Liver Disorder
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Hospitalization
- ☐ Kidney Disorder
- ☐ Mental Illness
- ☐ Pregnancy
- ☐ Premature Birth
- ☐ Physical Impairment
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia/Trait
- ☐ Speech Impairment
- ☐ Surgery
- ☐ Tuberculosis
- ☐ Vision Impairment

☐ **Check here if none of the conditions listed above apply.**

Please explain any of the above checked conditions or any serious medical conditions not listed____

____

Please list medication(s) your child has had a reaction to ____________________________

____

Please list medication(s) your child is currently taking ____________________________

____

Child's Physician__________________________**Physician's Phone# (_____)**______________

I understand that the above information represents my child's health history and that it will be held in the strictest of confidence. It is my responsibility to inform Canton Pediatric Dentistry, PLLC of any changes in my child's medical status.

____ ______________

Signature of Parent or Guardian **Date**

________________________________ ______________________

Print Name **Relationship to Child**

FOR STAFF USE ONLY:

I have reviewed the information above.

Staff Initial:

Date: