TELL US ABOUT YOUR CHILD

CHILD'S NAME_____ Preferred Name_____

[ ] Female [ ] Male Date of birth:_____Age:_____School:_____Grade:_____

Specific concerns:_____

Referred by (We wish to thank them):_____Address_____

Previous dentist: _____Last dental visit:_____
Has your child experienced any unfavorable reaction from previous medical or dental care? [ ] Yes [ ] No

If yes, please explain: _____

Is your child taking fluoride supplements? [ ] Yes [ ] No Dosage:_____

[ ] YES [ ] NO IS THERE A HEART CONDITION REQUIRING ANTIBIOTIC COVERAGE FOR DENTAL TREATMENT?

Does your child have a history of:

[ ] Excessive bleeding_____ [ ] Severe gag reflex_____
[ ] Teeth or jaw injury_____ [ ] Mouthbreathing/snoring_____
[ ] Jaw pain or TMJ_____ [ ] Speech therapy_____
[ ] Thumb/finger sucking or pacifier _____ [ ] Nursing/bottle after age one.

Is your child adopted? [ ] Yes [ ] No If yes, does he/she know? [ ] Yes [ ] No

MEDICAL HISTORY

Child's physician:_____Phone_____Address_____
Is your child under the care of a physician for any reason? [ ] Yes [ ] No If yes, please explain:_____
_____
Is your child presently taking any medications?_____
_____
Is your child allergic to any medications?_____
Is your child allergic to any dyes?_____
Is your child allergic to latex, metals, or acrylics?_____
Is your child allergic to nuts or tree nuts? _____

Has your child ever been diagnosed with or had any of the following conditions? Please check:

____Aids/HIV
____Allergies/hay fever
____Anemia
____Anoxeria/bulimia
____Asthma, if yes what triggers it? _____
Does child have inhaler? **Y N**
____Autism
____Bladder conditions
____Blood transfusions
____Birth defects/genetic disorders
____Bone/joint problems
____Cancer/malignancies
____Cerebral palsy
____Chemotherapy/radiation
____Child abuse
____Chronic adenoid/ tonsil infection
____Chronic ear infection
____Chronic sinus infection
____Cleft lip/palate
____Convulsions/seizures
____Developmental delay
____Diabetes
____Depression/anxiety
____Drug addiction
____Epilepsy
____Fainting or dizziness
____Fever blister/cold sores
____Headaches/migraines
____Hearing/speech impairments
____Heart murmur/defect/surgery
____Hemophilia
____Hepatitis/liver disease
____High blood pressure
____Hyperactivity/ADHD
____Kidney disease
____Pregnancy
____Premature birth
____Rheumatic fever
____Tuberculosis
____Other_____

If your child has or had a history of any of these conditions, please explain:_____
_____
_____

CONSENT FOR TREATMENT OF A MINOR

I understand the information given is correct. It is my responsibility to inform this office of any changes in my child's medical history. The undersigned hereby authorized Drs. Andrew and John Kapust and/or associates, and auxiliary personnel to perform dental care for my child. This consent shall remain active until cancelled by either party.

SIGNATURE OF PARENT
OR CUSTODIAL GUARDIAN_____**DATE**_____