



PATIENT INFORMATION

 Patient's Last Name First Name M.I. Home Telephone Birthdate

 Nickname Sex Street Address Town Zip
 Age and Name of Siblings _____

PARENT'S INFORMATION _____ Single _____ Separated _____ Married _____ Divorced _____ Widowed

 Parent #1 Name Birthdate Employer

 Parent #2 Name Birthdate Employer

 Parent #1 Work # Parent #1 Cell Phone # Parent #1 E-mail Address

 Parent #2 Work # Parent #2 Cell Phone # Parent #2 E-mail Address

 Previous or Family Dentist Address Telephone

 Child's Physician Telephone

Whom can we thank for referring you? _____
 Address _____

DENTAL HEALTH HISTORY

- Please check reason(s) for seeking dental care
 First Examination Routine check-up Toothache or swelling Appearance of teeth Crowding of teeth Accident
 Other _____
- If your child has been to a dentist previously? _____ Yes ___ No ___
 a. When was the last visit? _____
 b. Have x-rays been taken and when? _____
 c. How would you describe your child's dental treatment? _____
- How do you think your child will react to dental treatment? _____

- Has your child had fluoride in any of the following forms?
 Fluoride tablets or in vitamins (Fluoride amt.: .25 .5 1.0mg) (Please Circle) _____ Yes ___ No ___
 Drinking water (community fluoridation) _____ Yes ___ No ___
 Topical applications to teeth; date of last _____
 Toothpaste; brand _____
 Fluoride rinse/gel; brand _____
- Have your child's teeth ever been injured? _____ Yes ___ No ___
 When? _____ Which Teeth? _____ Cause? _____
 Were the teeth treated? _____ Yes ___ No ___
 If so, describe treatment _____
- Does your child have any of the following habits?
 Pacifier Lip sucking or biting Breathes through mouth Bottle to bed at night Thumb or finger sucking
 Other _____
- Has your child received any unusual dental or surgical treatment to the mouth? _____ Yes ___ No ___
 If so, what? _____

I hereby give my permission to Dental Associates of Walpole to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (injections), voice control, radiographs (x-rays), periodic exams and cleanings. I have received a Notice of the Privacy Practices of Dental Associates of Walpole.

Signature of Legal Guardian _____ Date _____

