DENTAL ASSOCIATES OF WALPOLE

DATE OF RECORD _____/_____/_____

REVIEWED BY: _____/_____

Staff Doctor

PATIENT INFORMATION

Patient's Last Name | First Name | Gender | Birthdate | Home Telephone

Address | Town | Zip | Patient's Physician | Phone

Parent/Guardian #1 Name | #1 Cell Phone | #1 Email

Parent/Guardian #1 gives permission to leave messages on phone regarding treatment: ❒ Yes ❒ No Billing? ❒ Yes ❒ No

Parent/Guardian #2 Name | #2 Cell Phone | #2 Email

Parent/Guardian #2 gives permission to leave messages on phone regarding treatment: ❒ Yes ❒ No Billing? ❒ Yes ❒ No

It is ok to send text messages and emails: Parent/Guardian #1 ❒ Yes ❒ No Parent/Guardian #2 ❒ Yes ❒ No

Marital status of parents: ❒ Married ❒ Single ❒ Separated ❒ Divorced ❒ Widowed

Who can we thank for referring you to our office? _____

DENTAL HISTORY

1. Do you have any concerns about your child's dental health? _____

   _____

   _____

2. When was your child's last dental visit? _____

   Where? _____

   What was done? _____

   X-Rays taken? _____

3. Does your child take fluoride? **YES** **NO** Use a fluoride rinse? **YES** **NO**

   Is there fluoride in your community water? **YES** **NO**

4. Does your child have any habits? Please **circle** any that apply:

   Pacifier **Mouth breathing** **Snoring** **Bottle/Sippy cup in bed** **Thumb/Finger sucking**

   Other habit _____

5. Is there anything else you would like us to know about your child's dental history? Trauma involving the mouth or face? Orthodontic treatment? Previous experiences at a dentist? Etc... ?

   _____

   _____

   _____

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MEDICAL HISTORY

1. Is your child under the care of a physician right now for a specific illness? **YES** **NO**

   _____

2. Is your child taking any medications? **YES** **NO**

REASON	MEDICATION	DOSE	FREQUENCY

3. Has your child shown any allergies or unusual reactions to any of the following (please be specific)? **YES** **NO**
   a. **Medications or drugs?**_____
   b. **Foods?** _____
   c. **Latex?**_____
   d. **Other?** _____
4. Are your child's immunizations up to date? **YES** **NO** If no, why? _____
5. Please **circle** any of the following that your child has a history of:

   Rheumatic Fever **Endocarditis** **Hepatitis** **Sickle Cell Disease or Trait** **Tuberculosis** **Cystic Fibrosis** **Jaundice**
   Bleeding Disorder **Leukemia or Tumors** **Diabetes** **Seizures** **Kidney Disease** **Asthma** **Anemia** **Cerebral Palsy**
   Liver Disease **AIDS** **Child Abuse** **Autism Spectrum Disorder** **Cyanotic Congenital Heart Disease**

   Learning Disabilities? Type?_____
   Emotional Disabilities? Type? _____
   Hearing or Speech Difficulty? _____
   Developmental Disability or **Delay?**_____
   Syndrome? Type? _____
   Is your child on a special accommodation plan at school?_____

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

Signature of Parent/Legal Guardian _____ Date _____

RE-EVALUATION OF ORIGINAL PATIENT MEDICAL INFORMATION

DATE	NO CHANGE	MEDICAL CHANGES	PARENT'S INITIALS	STAFF/DR INITIALS