WEST BOCA DENTISTRY FOR CHILDREN
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DATE _____

CHILD'S FIRST NAME_____LAST NAME_____ NICK NAME _____
AGE_____ BIRTHDAY_____ ADDRESS _____
_____ CITY _____ STATE _____ ZIP _____
TELEPHONE NO. _____CELL NO._____EMAIL ADDRESS _____
SCHOOL _____ GRADE _____
FATHER'S FIRST & LAST NAME _____ MOTHER'S FIRST & LAST NAME _____
BROTHERS _____ SISTERS _____
WHOM MAY WE THANK FOR REFERRING YOU _____
CHILD'S FAVORITE HOBBY _____ANY PETS _____
CHILD'S FAVORITE SPORT _____
FATHER'S SOCIAL SECURITY # _____ MOTHER'S SOCIAL SECURITY # _____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT/XRAYS _____
FOR WHAT _____
_____ BY DR. _____

	Yes	No
ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS _____	☐	☐
HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS _____	☐	☐
ANY INJURIES TO MOUTH, TEETH, HEAD _____	☐	☐
ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTHBREATHING, ETC. _____	☐	☐
ANY LOST TEETH _____	☐	☐

	Yes	No
DOES YOUR CHILD BRUSH DAILY _____	☐	☐
DO YOU ASSIST YOUR CHILD WITH BRUSHING _____	☐	☐
HOW OFTEN _____		
IS DENTAL FLOSS USED _____	☐	☐
ARE DISCLOSING TABLETS USED _____	☐	☐

HOW DOES YOUR CHILD RECEIVE FLUORIDE?
☐ WATER SUPPLY ☐ TOOTHPASTE ☐ DENTIST
☐ VITAMIN ☐ TABLETS ☐ DROPS
☐ NONE ☐ OTHER _____

CHILD'S ATTITUDE TOWARDS TODAY'S VISIT
_____
_____

WHO IS YOUR CHILD'S ORTHODONTIST (IF ANY)? _____
_____
WHO IS YOUR FAMILY DENTIST? _____

MEDICAL HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____
DATE OF LAST COMPLETE PHYSICAL EXAMINATION? _____ RESULTS _____

	Yes	No
IS YOUR CHILD IN GOOD HEALTH? _____	☐	☐
IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? _____	☐	☐
IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? _____	☐	☐
HAS YOUR CHILD EVER BEEN HOSPITALIZED? _____	☐	☐
HAS YOUR CHILD EVER HAD SURGERY? _____	☐	☐
DOES YOUR CHILD DRINK SODAS OR SPORTS DRINKS? _____	☐	☐
ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? _____	☐	☐

WHAT IS YOUR CHILD'S WEIGHT _____ HEIGHT _____
METHOD OF INFANT FEEDING _____ TO WHAT AGE? _____
EATING HABITS PRESENTLY - BRIEFLY EXPLAIN _____

DOES YOUR CHILD HAVE OR HAS ANY OF THE FOLLOWING HEALTH PROBLEMS?

	Yes	No
1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	☐	☐
2. CONGENITAL HEART DISEASE OR HEART MURMUR	☐	☐
3. ALLERGIES A) FOOD, DUST, ETC. _____	☐	☐
B) DRUG, i.e. Penicillin, etc. __	☐	☐
C) UNKNOWN _____	☐	☐
4. ASTHMA OR HAY FEVER _____	☐	☐
5. ARTHRITIS OR RHEUMATISM (PAINFUL, SWOLLEN JOINTS) _____	☐	☐
6. DIABETES OR BLOOD SUGAR PROBLEMS ___	☐	☐
7. ANY PROLONGED BLEEDING OR BRUISES EASILY _____	☐	☐
8. KIDNEY OR BLADDER PROBLEMS _____	☐	☐
9. ANEMIA OR BLOOD DISORDERS _____	☐	☐
10. TUBERCULOSIS OR PNEUMONIA _____	☐	☐
11. LIVER PROBLEMS, JAUNDICE OR HEPATITIS __	☐	☐
12. GLANDULAR OR HORMONAL PROBLEMS _____	☐	☐
13. ACCIDENTS OR SEVERE INFECTIONS _____	☐	☐
14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY _____	☐	☐
15. HIGH/LOW BLOOD PRESSURE _____	☐	☐
16. SPEECH, LEARNING, OR HEARING DISORDERS _____	☐	☐
17. CHILDHOOD ILLNESSES _____	☐	☐
18. IMMUNIZATIONS _____	☐	☐
19. AUTO IMMUNE DISORDER (I.E.-HIV) _____	☐	☐
20. OTHER, IF SO EXPLAIN _____	☐	☐

IF YES, PLEASE EXPLAIN _____

_____

_____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION WE SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

_____

_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		YOUR SPOUSE	
NAME		NAME	
OCCUPATION		OCCUPATION	
EMPLOYER		EMPLOYER	
BUSINESS ADDRESS	CITY	BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.	BUSINESS TELEPHONE	EXT.

I hereby certify the foregoing information is correct and true. Because_____ is a minor, it becomes necessary that a signed permission is obtained for a parent or guardian before any or all necessary dental treatment can be commenced. Authorization is hereby granted as such.

Furthermore, I will be responsible for any professional fees incurred for dental services to my child. In the event of defaulting payment, the financially responsible party assumes all costs of collection, including, but not limited to a 30% collection fee, court cost, interest, and legal fees.

Signed _____ Date: _____

Relationship: _____

SUMMARY: (FOR DOCTOR'S USE)