Print Form

CHART NUMBER _____

PEDIATRIC DENTISTRY
1308 WEST FLETCHER
TAMPA, FLORIDA 33612
(813) 264-6000

CHILD'S REGISTRATION AND PERSONAL HEALTH HISTORY

Please fill in the personal health history on the following pages. This information is an important aid in making a through evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs. This important document, therefore, becomes and integral part of our continuing evaluation of your child's growth and development in these formative years. This material is confidential.

Our thanks for your cooperation,

PATIENT HISTORY FORM

DATE _____

CHILD'S NAME _____ (LAST FIRST MIDDLE I) NICKNAME _____ AGE ____

ADDRESS _____ CITY _____ ZIP _____

PHONE _____ BIRTHDATE _____ Sex: ◯M ◯F

FATHER'S NAME DR. MR. _____ (LAST FIRST MIDDLE I) BIRTHDATE _____

FATHER'S SSN _____ FL. DR. LIC # _____

MAILING ADDRESS if different _____ CITY _____ ZIP _____

PHONE if different _____

EMPLOYER NAME _____ ADDRESS _____ BUS. PHONE _____

MOTHER'S NAME DR. MRS. MISS MS. _____ (LAST FIRST MIDDLE I) BIRTHDATE _____

MOTHER'S SSN _____ FL. DR. LIC # _____

MAILING ADDRESS if different _____ CITY _____ ZIP _____

PHONE if different _____

EMPLOYER NAME _____ ADDRESS _____ BUS. PHONE _____

DENTAL INSURANCE CARRIER NAME _____

ADDRESS _____ POLICY # _____

INSURANCE SIGNATURE _____ INSURANCE TELEPHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU _____

NAME AND BIRTHDATES OF OTHER CHILDREN _____

_____

FAMILY DENTIST _____ PHONE _____

CHILD'S PHYSICIAN _____ PHONE _____

MEDICAL HISTORY

CONDITION OF CHILD'S HEALTH _____

DATE AND REASON FOR RECENT MEDICAL EXAM _____

_____

NAME (S) OF ANY MEDICATIONS (S) TAKEN RECENTLY BY YOUR CHILD _____

HAS YOUR CHILD EVER BEEN ALLERGIC TO ANY MEDICINE, FOOD, OR SUBSTANCE -- LIST: _____

_____

HAS YOUR CHILD EVER BLED EXCESSIVELY FROM A CUT OR INJURY, OR BRUISED EASILY _____

- ☐ Anemia
- ☐ Asthma
- ☐ Bladder
- ☐ Blood Transfusion
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Sinus
- ☐ Convulsions
- ☐ Diabetes
- ☐ Digestion
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glands
- ☐ Hearing
- ☐ Heart
- ☐ Hepatitis
- ☐ Immune Deficiency
- ☐ Kidney
- ☐ Liver
- ☐ Malignancies
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Thyroid
- ☐ Tuberculosis

HAS YOUR CHILD EVER BEEN HOSPITALIZED _____ GIVE DETAILS _____

_____

HAS YOUR CHILD HAD ANY EMOTIONAL PROBLEMS _____

HOW DOES YOUR CHILD ACCEPT HIS PHYSICIAN _____

(over)

DENTAL HISTORY

WHAT IS YOUR MAIN REASON FOR BRINGING YOUR CHILD TO THIS OFFICE? _____

_____

ARE YOU SEEKING COMPLETE DENTAL HEATH CARE FOR YOUR CHILD? _____

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST?_____ IF NOT, WHEN WAS LAST VISIT _____ AND WHY _____

WHEN WAS LAST SET OF FULL MOUTH X-RAYS TAKEN _____ BY WHOM _____

HAS YOUR CHILD HAD TOPICAL FLUORIDE TREATMENT _____ WHEN _____

HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT _____

HAS ANY MEMBER OF YOUR FAMILY HAD ANY UNUSUAL DENTAL PROBLEMS?

_____

HAS THERE EVER BEEN ANY INJURY TO ANY OF THE TEETH OR THE MOUTH? _____

HOW OFTEN DOES YOUR CHILD BRUSH HIS/HER TEETH? _____

AGE OF CHILD WHEN TAKEN OFF BOTTLE _____ WHAT AGE WAS PACIFIER DISCONTINUED _____

CHILD'S INTERESTS, HOBBIES, TALENTS, etc. _____

_____

PLEASE LIST ANY QUESTIONS YOU WOULD LIKE TO HAVE ANSWERED _____

_____

_____

_____

THANK YOU FOR COMPLETING THIS PERSONAL HISTORY

CONSENT FORM

BECAUSE _____ IS A MINOR, IT BECOMES NECESSARY THAT SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/OR ALL NECESSARY DENTAL SERVICES AND METHODS CAN BE RENDERED, I BEING THE (FATHER) (MOTHER) (GUARDIAN) OF THE ABOVE NAMED CHILD, GIVE MY CONSENT TO THE PERFORMANCE OF SUCH TREATMENTS, SERVICES, MEDICA - TIONS, OPERATIONS, BEHAVIOR MANAGEMENT TECHNIQUES, LOCAL ANESTHESIA NECESSARY TO TREAT AND DENTAL/ORAL DEFICIENCY, ABNORMALITY AND/OR INFECTION.

Signed: _____ Date _____

IMPORTANT: PLEASE INFORM OUR OFFICE PRIOR TO ANY VISIT OF:

(1) ANY CHANGE IN YOUR CHILD'S PHYSICAL OR EMOTIONAL HEALTH

(2) ANY MEDICATION TAKEN BY YOUR CHILD WITHIN 48 HOURS BEFORE APPOINTMENT.

(3) 24 HOUR NOTIFICATION REQUIRED IF CANCELING APPOINTMENT. A FEE WILL BE ASSESSED FOR ANY BROKEN APPOINTMENTS WHICH LACK APPROPRIATE NOTICE.

MAY WE REQUEST YOUR CHILD'S MEDICAL RECORDS FOR OUR REFERENCE _____

_____

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