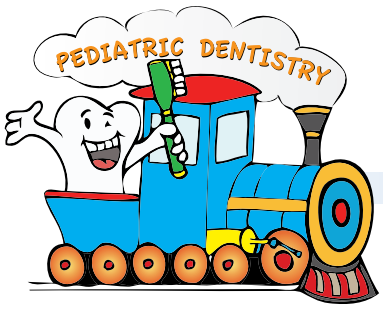

Robert C. Lee, D.D.S., M.S.
Diplomate, American Board of Pediatric Dentistry

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach proper oral health care that will enable your child to have a beautiful smile that lasts a lifetime. The information requested below is very important and becomes part of our permanent records. Please make sure your answers are as complete and accurate as possible.

Tell Us About Your Child:

Today's Date: _____

Name: _____

Nickname: _____

Birth Date: _____

Age: _____ Gender: ☐ Male / ☐ Female

Child resides with: Mother / Father Guardian Multiple Homes

Home Address _____
Street City Zip

School: _____ Grade: _____

Name/Age of Siblings: _____

Siblings Seen by Us That Child Lives With?

_____

Adopted? ☐ Y ☐ N

Who can we thank for referring you?

_____

Health History

Child's Physician: _____ Phone: (_____) _____

Date of last visit: _____ Address: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Are Immunizations Current? ☐ Yes ☐ No

Please list all medications and dosage that your child is currently taking:

_____

Please list all drugs and/or things (including Latex) that cause your child allergic reactions:

_____

Has your child had/experienced any of the following: (please circle)

Y ☐ N ☐ Abnormal Bleeding	Y ☐ N ☐ Developmental Delay	Y ☐ N ☐ Measles
Y ☐ N ☐ ADHD	Y ☐ N ☐ Diabetes	Y ☐ N ☐ Mitral Valve Prolapse
Y ☐ N ☐ AIDS/HIV+	Y ☐ N ☐ Endocrine System Disorders	Y ☐ N ☐ Mononucleosis
Y ☐ N ☐ Allergies	Y ☐ N ☐ Epilepsy	Y ☐ N ☐ Neurologic Disorders
Y ☐ N ☐ Anemia	Y ☐ N ☐ Frequent Infections	Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Any Hospital Stays	Y ☐ N ☐ Handicaps: _____	Y ☐ N ☐ Recurrent Headaches
Y ☐ N ☐ Any Operations	_____	Frequency:
Y ☐ N ☐ Asthma	Y ☐ N ☐ Hearing Impaired	Y ☐ N ☐ Scarlet Fever
Y ☐ N ☐ Autism Spectrum Disorder	Y ☐ N ☐ Heart Murmur	Y ☐ N ☐ Seizures
Y ☐ N ☐ Blood Dyscrasias	Y ☐ N ☐ Hemophilia	Y ☐ N ☐ Sickle Cell Anemia
Y ☐ N ☐ Blood Transfusion	Y ☐ N ☐ Hepatitis	Y ☐ N ☐ Sight Disorders
Date: _____	Y ☐ N ☐ High Blood Pressure	Y ☐ N ☐ Significant Injuries
Y ☐ N ☐ Breathing/Lung Problems	Y ☐ N ☐ Hives	List: _____
Y ☐ N ☐ Cancer/Tumors	Y ☐ N ☐ Kidney Problems	_____
Y ☐ N ☐ Chicken Pox	Y ☐ N ☐ Liver/GI System Problems	Y ☐ N ☐ Skin Rash
Y ☐ N ☐ Congenital Birth Defect	Y ☐ N ☐ Low Blood Pressure	Y ☐ N ☐ Tonsillitis
Y ☐ N ☐ Congenital Birth Disease	Y ☐ N ☐ Lupus	Y ☐ N ☐ Tuberculosis (TB)

1. Has your child ever been hospitalized? ☐ Yes ☐ No
   If so, when? _____ For what reason? _____
2. Has your child had any operations? ☐ Yes ☐ No
   If so, when? _____ For what reason? _____
   Was general anesthesia used? ☐ Yes ☐ No
   Any complications, if so, what? _____
3. Does your child bruise easily? ☐ Yes ☐ No
4. Has there ever been any history of spontaneous bleeding (e.g., nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? ☐ Yes ☐ No

REMARKS:

_____

_____

Dental History

1. Please check reason(s) for seeking dental care
   - ☐ First Examination
   - ☐ Routine check-up
   - ☐ Toothache or swelling
   - ☐ Appearance of teeth or face
   - ☐ Crowding Teeth
   - ☐ Accident

   Other _____

2. Has your child has been to a dentist previously? ☐ Yes ☐ No
   a. When was the last visit? Date _____
   b. Have x-rays been taken and when? ☐ Yes ☐ No Date _____
   c. How would you describe your child's temperament? _____

3. How do you think your child would react to dental treatment? _____

4. Has your child had fluoride in any of the following forms?
   Fluoride tablets or in vitamins (Fluoride amt. .25 .5 1.0 mg) ☐ Yes ☐ No
   Drinking water (community fluoridation) ☐ Yes ☐ No
   Topical application to teeth? ☐ Yes ☐ No When was last application _____
   Toothpaste: Brand _____

5. Does your child brush his/her own teeth? ☐ Yes ☐ No
   How frequent and when? A.M. ☐ P.M. ☐ After Snacks ☐ Before Bed ☐ After Breakfast ☐

6. Do you brush your child's teeth? ☐ Yes ☐ No _____
   How frequently and when? A.M. ☐ P.M. ☐ After Snacks ☐ Before Bed ☐ After Breakfast ☐

7. Do you or your child use dental floss in cleaning your child's teeth? ☐ Yes ☐ No
   How frequent and when? A.M. ☐ P.M. ☐ After Snacks ☐ Before Bed ☐ After Breakfast ☐

8. Have your child's teeth ever been injured?
   When? _____ Which teeth? _____
   Cause? _____
   Were the teeth treated? ☐ Yes ☐ No
   If so, describe treatment _____

9. Does your child have any of the following habits? (Indicate ages when occurred)
   Bottle to bed at night _____
   Thumb or finger sucking _____
   Pacifier _____
   Tongue thrusting _____
   Lip sucking or biting _____
   Breathes through mouth _____

10. Has your child received any unusual dental or surgical treatment to the mouth? ☐ Yes ☐ No
    If so, what _____

Guarantor Information

FATHER/GUARDIAN'S INFORMATION

Name: _____

☐ Single ☐ Married ☐ Divorced

Address: _____

City: _____ Zip: _____

Home Phone: (___) _____ Cell: (___)_____

Email: _____

Relationship to Patient: _____

Birthdate: _____

Social Security Number: _____

Occupation: _____

Employer: _____

Address: _____

Work Phone: (___) _____

Insurance Company Name: _____

Name of Policy Holder: _____

Insurance Company Address: _____

Insurance Company Phone: (___) _____

Group or Plan Number: _____

MOTHER/GUARDIAN'S INFORMATION

Name: _____

☐ Single ☐ Married ☐ Divorced

Address: _____

City: _____ Zip: _____

Home Phone: (___) _____ Cell: (___)_____

Email: _____

Relationship to Patient: _____

Birthdate: _____

Social Security Number: _____

Occupation: _____

Employer: _____

Address: _____

Work Phone: (___) _____

Insurance Company Name: _____

Name of Policy Holder: _____

Insurance Company Address: _____

Insurance Company Phone: (___) _____

Group or Plan Number: _____

In order to control the cost of dental services, we require that payment be made at the time of the service, unless otherwise discussed previously with our Financial Coordinator. Payment can be made with cash, personal check, MasterCard or Visa. If for any reason your check is returned to us, there will be an additional fee.

Please indicate the person responsible for payment fees:

Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell: (___)_____

Authorization & Release

CONSENT FOR TREATMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parents/Guardian _____ Date _____