Bradburn Village Dentistry

Child/Adolescent Patient Form

Today's Date: _____

Child's First and Last Name: _____Date of Birth: ____ - ____ - ____

Address: _____

Dental History

Has your child received dental treatment elsewhere? Yes_____ No_____ Don't Know_____

If yes, name of previous dentist: _____

What was his/her reaction? _____

Does your child have any toothaches that you're aware of? Yes_____ No_____

Does your child suck on a finger, thumb or pacifier? Yes_____ No_____ If yes, how often?_____

Has your child had any face, mouth or chin trauma? _____

Medical History

Please circle all that apply to your child.

Abnormal heart condition	Hepatitis	Congenital birth defects
Asthma	Heart murmur/MVP	Rheumatic fever
Arthritis	Tumor/cancer: type:_____	Latex/balloon allergy
AIDS/HIV	Seizures/epilepsy	ADD/ADHD
Diabetes	Cerebral palsy	Thyroid disease

Is your child allergic to any antibiotics (such as penicillin)? Yes_____ No_____ Don't Know_____

(OVER)

Does your child have any other medical conditions (if yes, explain)? _____

Does your child have a physical/mental/emotional handicap (if yes, explain)? _____

Is your child taking any medications (if yes, explain)? _____

Name of child's physician _____ Phone _____

May we contact your child's physician for additional information, if necessary? Yes_____ No_____

How do you expect your child will do today?

Very well_____ Well_____ Poor_____ Very Poor_____ Unsure_____

Parent First and Last Name _____

Parent Signature _____