WELCOME

CHILD'S NAME _____

Birth Date ____/____/____ **School** _____ **Grade** _____

Address_____**City & Zip** _____

Telephone ( ) _____ Social Security Number ____-____-_____

Mother's Name _____Father's Name _____
Parent's email_____

Name & Telephone of Pediatrician _____

Does your child currently take any medications?_____

Does your child have or has previously had the following health conditions: (Please circle yes or no)

Rheumatic fever or heart murmur ----------yes no
Allergies----------yes no
Asthma----------yes no
Diabetes----------yes no
Kidney problems----------yes no
Tuberculosis----------yes no
Hepatitis or liver problems----------yes no
Mitral valve prolapse----------yes no
Fainting or seizures----------yes no
Childhood illnesses—e.g. chicken pox----------yes no

Date of last visit to dentist _____Purpose of visit _____

Is there anything you would like us to know about your child's previous dental appointment?_____

PLEASE CONTINUE ON OTHER SIDE

Do you have any specific concerns about you child's teeth?_____

Thumb sucking _____ Pacifier _____ Speech problems _____

What type of water does your child drink?

City / Town _____ Well _____ Bottled _____

Whom may we thank for referring you to the office?

_____

Because _____ is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any necessary dental treatment can be delivered. Authorization is hereby granted as such. I also grant Dr. Patrice Foudy the right to release health information and dental treatment to third party payors and for other health care practitioners.

Signature _____ Relationship to Patient _____

Witness _____Date _____