

1. PATIENT'S HISTORY

Child's Full Name _____ Nickname _____

Birth: Date _____ S.S.# _____

Age _____ Sex _____ Race _____ School _____ Grade _____

Hobbies _____

Name and ages of brothers and sisters _____

_____ Child's Physician _____

2. GENERAL INFORMATION

Father's Name _____ Mother's Name _____

Home Address _____ Phone _____

City _____ Zip _____

Marital Status: Married Widowed Separated Divorced

Person responsible for payment of account _____

Occupation _____ Employed by _____

Business Address _____ Phone _____

Insurance Company _____ Employee _____

Birth Date: For Father _____ For Mother _____ Fathers S.S.# _____ Mothers S.S. # _____

Whom may we thank for referring you to this office? Please fill out; we like to thank our referrals!

Reason for this visit _____

Has any member of your family been a patient at our office? _____

Has your child ever been informed he/she needs to pre-medicate before dental procedures? _____

3. MEDICAL HISTORY

Has your child had:

	YES	NO		YES	NO		YES	NO
MEASLES	<input type="checkbox"/>	<input type="checkbox"/>	HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY – CONV.	<input type="checkbox"/>	<input type="checkbox"/>
MUMPS	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
CHICKEN POX	<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
WHOOPING C.	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE (H-L)	<input type="checkbox"/>	<input type="checkbox"/>	X-RAY THERAPY	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET F.	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
DIPHtheria	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
			LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	MOUTH INJURIES	<input type="checkbox"/>	<input type="checkbox"/>
			MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>

Is your child under medical care at present? _____ Explain _____

Date of last physical examination _____

Condition of child's general health _____

Is your child taking any medicines? _____ If so, what _____

Is your child mentally or physically handicapped? _____

Has your child had any surgery, oxygen therapy or general anesthetic? _____

Has your child had any history of sore throats, tonsillitis or earache? _____

Is your child allergic to food? _____ List _____

Is your child allergic to medicines? _____ List _____

Is your child allergic to penicillin? _____

Did your child ever receive antibiotics? _____ What _____

When (age) _____ How long? _____

Has your child been exposed to unpleasant dental or medical experiences? _____

Date of last dental care _____ Where? _____

Has your child ever had any reaction to dental anesthetic? _____

Did your child ever bleed excessively after a cut or removal of a tooth? _____

Has your child ever had a fluoridated tap water? _____ How long? _____

Fluoride solutions applied to teeth by a dentist? _____ How often? _____

Are fluoride tablets or vitamins prescribed by your dentist or physician? _____

Explain _____

AUTHORITY TO TREAT

I hereby authorize Dr. Radomski & Pewitt to treat the above mentioned patient using restorative and pain management techniques that are acceptable and proper. I understand that the treatment plan to be presented, as well as the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of decay.

Signed: _____

Relation to child: _____