



Pediatric Dental Acquaintance Form (Ages 1-6 yrs.)

Child's Name: _____ Sex: _____ Date of Birth: ___/___/___ Age: ___
Address: _____ City: _____ State: _____ Zip: _____
School: _____ Interests or Hobbies: _____
Primary Phone Number _____ Child Lives With _____
Responsible Financial Party: _____ Ages of Children at Home: _____
Do you have dental insurance? _____ With whom? _____

Guardian 1: _____ Relationship to Child _____
Date of Birth: _____ Guardian's Social Security: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ Home Address: _____
Bus. Phone: _____ Cell Phone: _____
Drivers license: _____ Email Address _____

Guardian 2: _____ Relationship to Child _____
Date of Birth: _____ Guardian's Social Security: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ Home Address: _____
Bus. Phone: _____ Cell Phone: _____
Drivers license: _____ Email Address _____

Physician: _____ City: _____ Phone: _____
Dentist: _____ City: _____ Phone: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

MEDICAL HISTORY-check the answer to the right and provide the details on the line:

Is your child in good health? Yes No _____

Approximate date of last physician visit and why? Yes No _____

Has your child ever had a serious illness? Yes No _____

Check any of the following conditions currently present or in past history:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS OR HIV POSITIVE | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY INVOLVEMENT | <input type="checkbox"/> LIVER INVOLVEMENT |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> ARTHRITIS OR JOINT DISEASE |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> ENDOCRINE PROBLEMS | <input type="checkbox"/> EMOTIONAL PROBLEMS |
| <input type="checkbox"/> BONE DISORDERS | <input type="checkbox"/> PROLONGED BLEEDING | <input type="checkbox"/> NERVOUS DISORDER |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> FAINTING OR DIZZINESS |
| <input type="checkbox"/> MUMPS | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> LATEX ALLERGIES | <input type="checkbox"/> DENTAL PHOBIA | <input type="checkbox"/> SENSITIVE GAG REFLEX |

Any additional information we should know: _____

Does your child have any physical or mental disabilities or handicaps? Yes No Explain: _____

Please list all prescription drugs or medications taken in the last 3 months (give reason): _____

Has the child ever experienced an unusual reaction (allergy or sensitivity) to any of the following medicines? If yes, please check:

- Aspirin Penicillin Sulfonamides (Sulfa) A Dental Local Anesthetic(lidocaine) Ataraxic(Tranquilizers) Latex

Please list any other allergies or drug sensitivities: _____

HABITS AND PERSONALITY

Does your child have any of these habits:

- Thumb or finger sucking Mouth breathing Tongue thrust (abnormal swallowing) Clenching or grinding teeth
 Other Oral habits _____

DENTAL HISTORY

When was your child's last dental visit (approximate date?) ___/___/_____

Was all recommended dental work completed? Yes No

Have there ever been any injuries to the face, mouth, or teeth?..... Yes No

Does your child brush his or her teeth 3 times a day?..... Yes No

Does he or she floss daily?..... Yes No

CONSENT (please read and sign below)

Your child is a minor: it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including diagnostic radiographs. If my child ever has a change in his/her health or medications, I will inform the doctor at the next appointment without fail.

Date: _____ **Name:** _____ **Signature:** _____

Notes/Updates: _____
