DAVID C. ADAMS, D.D.S., M.S., AND ASSOCIATES

SPECIALISTS IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALISTS IN PEDIATRIC DENTISTRY

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:_____ Do you have dental insurance? _____

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

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:

☐ AIDS OR HIV POSITIVE	☐ ASTHMA	☐ EPILEPSY
☐ DIABETES	☐ KIDNEY INVOLVEMENT	☐ LIVER INVOLVEMENT
☐ HEART TROUBLE	☐ GLAUCOMA	☐ ARTHRITIS OR JOINT DISEASE
☐ RHEUMATIC FEVER	☐ ENDOCRINE PROBLEMS	☐ EMOTIONAL PROBLEMS
☐ BONE DISORDERS	☐ PROLONGED BLEEDING	☐ NERVOUS DISORDER
☐ HEPATITIS	☐ TUBERCULOSIS	☐ FAINTING OR DIZZINESS
☐ MUMPS	☐ CHICKEN POX	☐ MEASLES
☐ LATEX ALLERGIES	☐ DENTAL PHOBIA	☐ SENSITIVE GAG REFLEX

Any additional information we should know: _____
_____
_____

(Please turn page over)

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

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:** _____