Children's Dental Place of Wellington, Inc.
General Dentist Limited to Pedodontics

Child's Name (last) _____(first)_____Nickname_____M__F__
Age ____Birthdate_____Home Phone #_____Cell #_____
Residence Address_____City_____Zip Code_____
Father's Name(last)_____(first)_____
Mother's Name(last)_____(first)_____
Married____Divorced____Single____Widowed____
Head of Household's Occupation_____
Father Employed by_____Address/phone_____
Mother Employed by _____Address/phone_____
If applicable Dental Insurance Carrier(s) name_____
Whom may we thank for referring you to our office?_____
Mother's SS# _____Father"s SS#_____
Mother's Drivers License#_____Father's Drivers License#_____
Mother's Date of Birth _____Father's Date of Birth_____
Parent's General Dentist_____ number of years seeing this Dentist_____
PRIMARY REASON FOR THIS VISIT_____
OTHER SIBLINGS THAT ARE OUR PATIENTS_____
Child lives with _____

DENTAL HISTORY Yes/No

Date of last dental visit_____
for what _____
by Dr. _____
Any previous unhappy medical or dental visits _____ __ __
Has your child complained of any dental problems?_____ __ __
Any injuries to mouth, teeth, head? __ __
Any oral habits? Thumbsucking, pacifier? __ __
Any lost teeth? _____ __ __
Has your child seen an orthodontist? __ __
If so, orthodontist's name_____

Yes/No

Does your child brush daily? __ __
Does your child floss daily? __ __
Do you assist your child with brushing or flossing? __ __

How does your child receive Fluoride? water supply__
toothpaste__Dentist__
vitamin__tablets__ None__
other _____
Child's attitude toward Dentistry _____

Child's Physician Dr._____Address_____Phone_____
Date of last complete physical examination _____
Results _____

yes / no

Is your child in good health ? __ __
Is your child presently under physicians care? __ __
if yes, for what _____
Is your child receiving any medications or drugs? __ __
if yes, which ones _____
What is your child's weight _____height _____

Has your child ever been hospitalized? _____
Has your child ever had surgery? _____
Method of infant feeding _____
Are there any psychological or emotional problems you would like to bring to our attention? _____
Are you childs immunizations up to date? _____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
1. HEART MURMUR			11. Liver problem, jaundice or hepatitis		
2. Rheumatic fever, blood disorders or congenital heart disease			12. Glandular or hormonal problems		
3. Allergies: Latex, food, Penicillin, unknown _____			13. Accidents or severe infections		
4. Asthma or hay fever			14. Convulsions, seizures, fainting or epilepsy		
5. Arthritis or rheumatism, (painful, swollen joints)			15. High/low blood pressure		
6. Diabetes or blood sugar problems			16. Speech, learning or hearing disorders		
7. Any prolonged bleeding or bruises easily.			17. Childhood illnesses		
8. Kidney or bladder problems			18. Other _____		
9. Anemia					
10. Tuberculosis					

19. Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed _____

It is our policy to receive payment as our treatment progresses. The appointment time is reserved specifically for your child. If you find you cannot keep a scheduled appointment, please call 24 hours in advance so that we may reschedule your child at a convenient time and to enable us to fill this cancellation with another patient. If you do not call within 24 hours , a BROKEN APPOINTMENT CHARGE will be applied.

PATIENTS PARENT(s) AGREES TO BE RESPONSIBLE FOR LEGAL FEES, COLLECTION COSTS, AND COURT COSTS INCURRED BY THE DOCTOR IN CONNECTION WITH THE COLLECTION OF ANY ACCOUNT BALANCE.....
I hereby certify the foregoing information is correct and true.. Because _____ __ is a minor, it becomes necessary that this signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment or behavioral management can be commenced. Authorization is hereby granted as such.. Furthermore, I will be responsible for any professional fees incurred for dental services to my child.

Signed _____ Date _____
Relationship _____