Children's Dental Place of Boca Raton, 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 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_______________

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 ______________________________