COMMONWEALTH PEDIATRIC DENTAL SPECIALISTS

DR. JOY

DENTAL HISTORY

Patient Name: ____________________________

DENTAL CONCERNS

What is the primary reason for today's visit? ☐ Cleaning ☐Trauma/Dental Emergency ☐Consult for Decay(cavities)

Further explanation____

Has your child ever been to the dentist? ☐Yes ☐ No **(If Yes) Previous/Present Dentist:** ____________________________

Date Last Exam: ______________________________ **Date Last X-rays:** ______________________________

Describe your child: ☐Outgoing ☐Shy ☐Stubborn ☐Anxious ☐Frightened ☐Age Appropriate

How would you expect your child to behave in our office? ____

How may we help make this visit a positive experience for your child? ________________________________

Does your child currently...(Check all that apply)

☐Bottle Feed Until what age? _____________ ☐Breast Feed Until what age? _____________

HYGIENE ROUTINE

(Check all that apply)

☐Fluoride Toothpaste ☐Consume Fluoridated Water ☐Brushing by Child: _______/day ☐Brushing by Parent: ________/day

☐Fluoride Mouthwash ☐Dental Floss: ________x/week ☐Snacks between Meals – *Types of Snacks*: _________________

REFERRAL INFORMATION

Please share with us how you heard about our office…

☐ Sibling(s):____________________________________

☐ Friend:_______________________________________

☐ Pediatrician/Physician: __________________________

☐ Dentist/Dental Office: ___________________________

☐ Insurance:____________________________________

☐ School/Daycare: _______________________________

☐ Other: _______________________________________

☐ Google

☐ Website

☐ Facebook

☐ Angie's List

☐ Print Ad(magazine, newspaper, etc):_______________________

☐ Community Event:____

FRIENDS AND FAMILY CONSENT

I give consent for the following family members and friends to accompany my child to his/her dental appointments and to act on my behalf to give consent for any dental or diagnostic treatment. I also give permission for the following people to receive private information about my child regarding treatment, dental conditions, and health history as it pertains to the dental visit. I further understand that whoever should bring my child to his/her appointment, will be responsible for payment at the time services are rendered.

If any questions arise, I may be reached at (phone number) (_____)_______-__________. ________________________Signature

Family/Friend Name____ Relationship to patient _________________

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