



CHILD'S NAME _____ BIRTH DATE _____ SEX _____ AGE _____

GUARDIAN #1 NAME _____ BIRTH DATE _____ S.S. # _____

GUARDIAN #1 ADDRESS _____ CITY _____ STATE _____ ZIP _____

GUARDIAN #1 EMPLOYER _____

CELL PHONE _____

EMAIL ADDRESS _____

GUARDIAN #2 NAME _____ BIRTH DATE _____ S.S. # _____

GUARDIAN #2 ADDRESS _____ CITY _____ STATE _____ ZIP _____

GUARDIAN #2 EMPLOYER _____

CELL PHONE _____

EMAIL ADDRESS _____

CHILD'S MEDICAL DOCTOR _____ LAST VISIT _____

REASON _____

NAME OF PRIMARY DENTAL INSURANCE _____ NAME OF SECONDARY DENTAL INSURANCE _____

NAME OF INSURED _____ NAME OF INSURED _____

INS. I.D. # _____ INS. I.D. # _____

HOW DID YOU LEARN ABOUT THIS OFFICE? _____

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PLEASE READ CAREFULLY:

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/AND ALL NECESSARY DENTAL SERVICES CAN BE STARTED AND ACCOMPLISHED BY THE DOCTORS HERE AT FAIRFIELD PEDIATRIC DENTISTRY.

AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEE CHARGED FOR THIS DENTAL AGREEMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO DENTAL CLAIMS TO MY INSURANCE COMPANY.

**** NOTE: OUR OFFICE POLICY IS THAT ALL ACCOUNTS **
WILL BE BILLED TO THE GUARDIAN
AUTHORIZING DENTAL TREATMENT**

Signature _____ Relationship _____ Date _____

MEDICAL INFORMATION

Please read and answer EACH question. Please check (✓) if your child has had any problem or history of the following. If you need assistance, we will be glad to help you.

	YES	NO
1. Allergies	_____	_____
a) To any medications (drugs)	_____	_____
b) Latex	_____	_____
c) Other	_____	_____
2. Anemia	_____	_____
3. Anxiety or Depression	_____	_____
4. Arthritis	_____	_____
5. Asthma	_____	_____
6. Autism Spectrum	_____	_____
7. Emotional Differences	_____	_____
8. Cerebral palsy	_____	_____
9. Convulsions or seizures	_____	_____
10. Cystic Fibrosis	_____	_____
11. Developmental Delays	_____	_____
12. Diabetes	_____	_____
13. Hearing Difficulties	_____	_____
14. Heart problems or murmur	_____	_____
15. Hepatitis	_____	_____
16. Hyperactivity or ADHD	_____	_____
17. Kidney disorders	_____	_____
18. Learning Differences	_____	_____
19. Liver disorders	_____	_____
20. Malignancy or leukemia	_____	_____
21. MTHFR gene mutation	_____	_____
22. Pregnancy	_____	_____
23. Sensory Processing Disorder	_____	_____
24. Special needs	_____	_____
25. Speech Delay	_____	_____
26. Tuberculosis	_____	_____
27. Vomiting, GERD, Reflux	_____	_____

If any of the above are checked "YES", please give a brief explanation: _____

Is your child presently taking any medications? _____ If so, what and prescribed by whom? _____

Has your child ever taken penicillin or amoxicillin? _____ Any allergic reactions? _____

Has your child ever been hospitalized? _____ If so, for what reason? _____

Has your child ever had surgery or received any transfusions of blood, blood products or blood elements? _____

Does your child have any medical problems not listed above? _____

DENTAL INFORMATION

Last visit to a Dentist _____

Current dental problem? _____

Any unhappy dental visits? _____

Any injuries to the mouth, teeth, or head? _____

Any mouth habits (thumb-sucking, etc.)? _____

Has your child had dental X-Rays before? _____

Has your child had toothaches in the past? _____