Dr. Monica Mosley

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Demographic Information

Patient: ______________________________ Date: ______________

Nickname: ______________ Guardian's Email: ______________________

Birthday: ____________ Age: ______ Sex: ______ Ethnicity: ____________

Home Phone: ____________ Cell Phone: ____________ Secondary Cell Phone: ____________

Home Address: ____

Names & Ages of Siblings: ______________________________________

Patient School: ______________________________ Patient Grade: ____________

Parent/Legal Guardian: ______________________________ Relationship to Patient: ________

Employer: ______________________________ Phone: ____________

Parent/Legal Guardian: ______________________________ Relationship to Patient: ________

Employer: ______________________________ Phone: ____________

Who has legal custody of patient? ______________ Dental Insurance: ☐ YES ☐ NO

May be contacted via text message: ☐ YES ☐ NO Phone: ______________________

Dental Insurance: ______________________________ ID Number: ____________

Policy Holder: ______________________________ DOB: ____________

Employer: ______________________________ SS#: ____________

Secondary Dental Insurance: ______________________________ ID number: ____________

Policy Holder: ______________________________ DOB: ____________

Employer: ______________________________ SS#: ____________

Person Responsible for Payment of Account: ______________ SS#: __________ DOB: ________

Name of Child's Physician/Group: ______________________________________

Phone #: ______________________ City/State: ______________________

Whom may we thank for referring you to us? ______________________________

What is the reason for your child's dental visit? ______________________________

Health History

☐ YES ☐ NO Is your child in good health? Date of last physical exam: ____________

☐ YES ☐ NO Has your child ever has a health problem? ____________

☐ YES ☐ NO Is your child current on their vaccinations? If no, please explain: ____________

____

☐ YES ☐ NO Has your child ever been hospitalized? Please give a reason and dates: ____________

____

☐ YES ☐ NO Is your child allergic to anything? ____________

☐ YES ☐ NO Is your child currently taking any medications? Please give medication, dose and reason:

____

☐ YES ☐ NO Were there any problems at birth? ____________

Please circle if your child has been treated for any of the following:

Heart Disease	Bleeding/Transfusions	Asthma/Breathing	Blood Dyscrasias
Liver/GI Disease	Anemia	Diabetes	AIDS
Kidney Disease	ADD/ADHD	Hepatitis	Mental Delays
Speech/Hearing	Seizures	Cleft Lip/Palate	Physical Delays
Eyesight	Congenital Birth Defects	Personality/Social	Other Problems
Cancer/Tumors	Recurrent Headaches	Frequent Infections	Adverse Drug Reactions
Cerebral Palsy	Significant Injuries	Endocrine/Growth	Autism

Please elaborate on any items circled: ____________

____

____

Do you consider your child to be:

☐ Advanced in the learning process

☐ Progressing normally

☐ Slow in the learning process

Was your child:

☐ Breast Fed At what age stopped: ____________

☐ Bottle Fed At what age stopped: ____________

Dental History

☐ YES ☐ NO Has your child ever been to the dentist? Date of last xrays (if taken)

Name of dentist & date: ______________________

☐ YES ☐ NO Has your child experienced any unfavorable reaction from previous dental care?

Explain: ______________________

☐ YES ☐ NO Does your child suck a finger, thumb or pacifier?

☐ YES ☐ NO Does your child have pain with chewing, yawning, or wide opening?

☐ YES ☐ NO Does your child's jaw make noise and is pain associated with the sounds?

Please circle if your child is having problems with any of the following:

Cavities	Toothache	Sensitive Teeth	Comments: ______________________
Trauma	Gum Infections	Color of Teeth	______________________
Orthodontics	Jaw Sounds	Other	______________________

Please estimate your child's daily exposure to the following items:

Soda: ______________________

Juice: ______________________

Sports Drinks: ______________________

Cookies/Crackers: ______________________

Choco/Strawberry Milk: ______________________

Cereal Bars/Granola Bars: ______________________

Gummies/Gummy Vitamins: ______________________

Fruit Snacks/Fruit Roll-Ups: ______________________

Dried Fruit: ______________________

Potato Chips: ______________________

Fluoride History

☐ YES ☐ NO Is your home water supply fluoridated?

☐ YES ☐ NO Does your child use a fluoride toothpaste?

☐ YES ☐ NO Do you give your child any other form of fluoride? What? ______________________

Consent for Dental Treatment

I request and authorize Dr. Mosley to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Mosley to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Mosley will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature: ______________________ **Date:** ______________________