Danville
PEDIATRIC DENTISTRY

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: _____

City: _____ State: _____ Zip Code: _____

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:** _____