TODAY'S DATE_______________

PATIENT'S NAME______________________________ DATE OF BIRTH_____________

PERSON WITH PATIENT TODAY________________________ RELATIONSHIP TO CHILD_____________

PHONE#____________________ CELL#____________________

EMAIL ADDRESS______________________________

ANY CHANGE IN ADDRESS Y N IF YES,______________________________

ANY CHANGE IN INSURANCE Y N IF YES,______________________________

DO YOU HAVE ANY CONCERNS FOR THE DOCTOR TODAY?______________________________

Has the child ever had any unhappy dental visits? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Child's Physician: ______________________

Phone #: ______________________

Date of last visit to physician: ______________________

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

____

____

Consent to bring child to appointment for treatment & Consent to Release Medical Information

I grant permission for the person(s) listed below (other than the parent/legal guardian) to bring my child to Pediatric Dentistry of Cleveland and Ooltewah for dental treatment. I also grant permission for the person(s) listed below (other than the parent/legal guardian) to have access to any and all of my child's medical information that pertains to his/her care from the dentists of this group. This includes, but is not limited to, appointment times, his/her dentist's plans for dental care, etc. This consent can be revoked at anytime by submitting to Pediatric Dentistry of Cleveland and Ooltewah in writing a letter requesting to terminate this consent.

______________________ ______________

NAME RELATIONSHIP TO CHILD

______________________ ______________

NAME RELATIONSHIP TO CHILD

______________________ ______________

NAME RELATIONSHIP TO CHILD

______________________ ______________

NAME RELATIONSHIP TO CHILD

X______________________________

SIGNATURE OF PARENT OR LEGAL GUARDIAN

PLEASE MARK IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

- ❑ Abnormal Bleeding/Hemophilia
- ❑ Allergies
- ❑ Anemia
- ❑ Anaphalaxis
- ❑ Any Hosptial Stays/Operations
- ❑ Artificial Heart Valve/Joint
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Chemotherapy/Radiation
- ❑ Chicken pox
- ❑ Cleft lip/Palate
- ❑ Convulsions/Epilepsy/Seizures
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Down Syndrome
- ❑ Emotion, Mental, Nervous Disorder
- ❑ Frequent Nose Bleeds
- ❑ Handicaps/Disabilities
- ❑ Hearing Impairment
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis
- ❑ Herpes/Cold Sores
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Intellectual Disability
- ❑ Kidney/Liver Problems
- ❑ Leukemia
- ❑ Measles
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Pregnancy
- ❑ Premature Birth
- ❑ Renal Dialysis
- ❑ Rheumatic/Scarlet Fever
- ❑ Sickle Cell Disease
- ❑ Speech Difficulties
- ❑ Thyroid Disease
- ❑ Tuberculosis (TB)
- ❑ Vision Problems
- ❑ Any Syndromes

IF ANY OF THE ABOVE ARE CHECKED, PLEASE GIVE A BRIEF EXPLANATION______________________________

____

Are your child's immunizations up to date? ❑ Yes ❑ No

Does your child have any drug allergies? ❑ Yes ❑ No

If yes, please list______________________

Is your child allergic to latex? (Balloons, Bandaids, Bananas) ❑ Yes ❑ No

Please list any previous hospitalizations/surgeries/serious illnesses:

____

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