SOUTHMOOR PEDIATRIC DENTISTRY, P.C.

Bradley R. Smith DDS, MS
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Child's Name_____ Date ____/____/____
Date of Birth ____/____/____ Current weight_____lbs.

So that we may know and better understand your child, and be better prepared to render the best possible health service, it is requested that you complete the following:

DENTAL HISTORY

1. Has your child had dental treatment elsewhere? _____
   What was his or her reaction? _____
2. Does your child have any dental complaints? _____
   How long? _____
3. Is there anything you would like us to know so that we can better care for your child? _____

MEDICAL HISTORY

Has your child ever had:	Yes	No
Abnormal Heart Condition	☐	☐
ADD/ADHD	☐	☐
Asthma/Respiratory Disease	☐	☐
Autism Spectrum Disorder	☐	☐
Blood Disorders (ex. Anemia, Hemophilia, HIV, Hepatitis)	☐	☐
Cancer	☐	☐
Diabetes	☐	☐

	Yes	No
Genetic Disorder/Syndrome	☐	☐
Intestinal/Stomach Problems	☐	☐
Kidney Problems	☐	☐
Liver Problems	☐	☐
Mental, Emotional or Developmental Delays	☐	☐
Neurologic Disorder (ex. CP, seizures)	☐	☐
Any Surgical History	☐	☐

Is your child allergic to:		
Penicillin	☐	☐
Sulfa	☐	☐
Any Medication	☐	☐

Has your child ever had a local anesthetic?	☐	☐
Current on immunizations?	☐	☐

Does your child have any special health care needs? _____
Is your child taking medication? _____
If so, for what? _____
Name of Physician: _____
Address: _____
Phone: _____
May we contact your child's physician for additional information, if necessary? _____

	Yes	No
Does your child have or had frequent headaches?	☐	☐
History of TMJ (jaw joint) dysfunction?	☐	☐
Any congenital birth defects?	☐	☐
Does your child suck a finger, thumb or pacifier?	☐	☐
Does your child sleep with a nursing bottle?	☐	☐

Relieved by: _____

Date of last physical exam _____
Date of last dental exam _____
Date of last dental x-rays _____
Briefly describe your child's personality/temperament _____

(Please Complete Next Page)

CONSENT

Because your child is a minor it is necessary that a signed permission form be obtained from a parent or legal guardian before any treatment can be started or completed by one of our doctors. This form is for the purpose of explaining our usual office policies and procedures regarding patient care. While signing this form gives consent for us to treat your child, we encourage you to speak to any of our staff members, especially our doctors, if you have any questions regarding your child's specific needs or the treatment being provided. We always prefer to discuss your child's proposed treatment beforehand, whether it is diagnostic or restorative.

Our examination will include a hard tissue and soft tissue examination. Dental X-Rays may or may not be taken, depending on your child's age, specific dental needs and their ability to cooperate. While not every patient gets dental X-Rays every visit, diagnostic X-Rays are necessary from time to time as your child grows. Photographs for diagnosis, treatment planning and teaching may also be taken.

Restorative and surgical treatments may be needed depending on your child's specific needs; you will be consulted in advance before any treatment. The restorative materials used may include composite resin fillings, dental sealants, silver amalgam fillings, composite resin crowns and stainless steel crowns. Restorative treatment may include nerve treatment ("pulpotomy" or "pulp capping") when necessary due to deep dental decay. Surgical treatment may include but not limited to tooth removal and minor gum or soft tissue surgery. Local anesthesia is routinely used if necessary for your child's comfort. Your child's treatment needs, if any, will be reviewed with you by the doctor at the end of the examination appointment, and before any treatment is started.

No sedative drugs are used, including nitrous oxide ("laughing gas") without prior consent by a parent. If a cooperation problem arises and we feel such sedation is indicated, you will be consulted in advance. Physical restraint is not used without a parent's consent, except as needed to protect a child from accidental self-injury during treatment. An assistant may hold your child's hands if we are concerned your child will reach up while the doctor is working.

I acknowledge that I will be responsible for arranging for payments of any bills incurred for the dental treatment on the above child.

PARENT OR GUARDIAN _____ WITNESS _____

HEALTH HISTORY UPDATES