Fara Bender, DMD **Pediatric Dentistry**
6169 Jog Road • Suite B-5 • Lake Worth, FL 33467 • Telephone: (561) 433-5544 • Fax: (561) 433-4440

Get Acquainted Questionnaire & Health History Form

Date _____

Patient _____ Name child would like to be called _____

Date of Birth ___ /___ /___ Age _____ y _____ m Gender □ M □ F Weight _____ lb.

Address _____

City _____ State _____ Zip Code _____ Phone _____

Who has legal custody of patient? _____ Relationship _____

Email for appointment reminders:_____ Text reminders:_(_____)_____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? □Y □N
Name of Insured _____ Date of Birth ___ / ___ / ___ SS# _____
Employer _____ City _____ State ____ Zip _____ Phone _____
Insurance Company _____ Group # _____ Phone _____
Insurance Address _____ City _____ State _____ Zip _____

Mother's Name _____ SS# _____DOB_____ Home/Cell Phone _____

Mother's Employer _____ Occupation _____Work Phone _____

Father's Name _____ SS# _____DOB_____ Home/Cell Phone_____

Father's Employer _____ Occupation _____Work Phone _____

Name of Child's School _____ Grade _____

Names and ages of other children in the family _____

Whom may we thank for referring you to our office? _____

Dental History

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

Previous Dentist's Name _____ City _____

Date of last Dental Exam _____ Date of last dental x-rays _____

☐ **Y** ☐ **N** Has your child had any unhappy dental experience? Explain _____
_____

☐ **Y** ☐ **N** Does your child brush his/her teeth? How often ? _____ ☐ Alone ☐ Supervised ☐ Assisted

☐ **Y** ☐ **N** Does your child floss his/her teeth? How often ? _____ ☐ Alone ☐ Supervised ☐ Assisted

☐ **Y** ☐ **N** Does your child use a fluoride toothpaste?

☐ **Y** ☐ **N** Is your home water supply fluoridated?

☐ **Y** ☐ **N** Does your child receive any other form of fluoride? If so, what?_____

Was your child ☐ Breast fed ☐ Bottle fed At what age was it stopped? _____

Does your child **frequently** ☐ Drink juice ☐ Drink soda ☐ Eat sweets

Please check if your child has or has ever had any of the following conditions:

□ Cavities
□ Accident/Injury to teeth
□ Crowded/Spaced teeth
□ Snoring/Mouth Breathing
□ Toothache
□ Discolored/Stained teeth
□ Bleeding/Infected gums
□ Pacifier/finger/thumb habit
□ Cold sores/Canker sores
□ Tooth Grinding/Clenching
□ Sleeping with bottle/nursing at will
□ Other _____

Explain _____

Health History

Name of child's physician _____ Date of last physical exam _____

Address _____ Phone _____ Fax _____

☐ **Y** ☐ **N** Is your child in good health? If no, state health problem _____

☐ **Y** ☐ **N** Are all vaccinations up to date? If no, explain _____

☐ **Y** ☐ **N** Were there any problems at birth? If yes, explain _____

☐ **Y** ☐ **N** **Is your child allergic to anything?** If yes, explain_____

☐ **Y** ☐ **N** Does your child have a heart murmur? If yes, explain_____

(*If you are unsure of the type of heart murmur, please contact your child's physician as certain heart murmurs require antibiotic pre-medication prior to dental treatment.)*

☐ **Y** ☐ **N** Has your child ever been treated in an emergency room? If yes, when? _____ Why? _____

☐ **Y** ☐ **N** Has your child ever been hospitalized? If yes, when? _____ Where?_____ Why? _____

☐ **Y** ☐ **N** Has your child ever had surgery? If yes, when? _____ Where?_____ Why? _____

☐ **Y** ☐ **N** **Is your child currently taking <u>any</u> medication?** If yes, please complete below.

List Medication(s):	Dosage/Frequency	Treatment for:	Date Started:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does this child have or has this child ever had any of the following conditions:

☐ **Y** ☐ **N** Drug reactions
☐ **Y** ☐ **N** Latex allergy
☐ **Y** ☐ **N** Environmental/Seasonal allergies
☐ **Y** ☐ **N** Asthma
☐ **Y** ☐ **N** Breathing problems
☐ **Y** ☐ **N** Sickle Cell Anemia
☐ **Y** ☐ **N** Heart Condition/Murmur
☐ **Y** ☐ **N** Rheumatic Fever
☐ **Y** ☐ **N** Anemia
☐ **Y** ☐ **N** Bleeding Problems
☐ **Y** ☐ **N** Seizures
☐ **Y** ☐ **N** Hyperactivity/ADD/ADHD
☐ **Y** ☐ **N** Recurrent Infections
☐ **Y** ☐ **N** TB HIV Hepatitis
☐ **Y** ☐ **N** Kidney Disease
☐ **Y** ☐ **N** Liver/GI Disease
☐ **Y** ☐ **N** Hypertension
☐ **Y** ☐ **N** Diabetes
☐ **Y** ☐ **N** Cancer/Tumors
☐ **Y** ☐ **N** Birth Defects
☐ **Y** ☐ **N** Cleft Lip/Palate
☐ **Y** ☐ **N** Cerebral Palsy
☐ **Y** ☐ **N** Developmental Delay
☐ **Y** ☐ **N** Psychiatric/Emotional Problems
☐ **Y** ☐ **N** Speech Delay
☐ **Y** ☐ **N** Other _____

Do you consider your child to be ☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

How do you think your child has reacted to past medical/dental procedures? ☐ very good ☐ good ☐ poor ☐ very poor

How do you expect your child to react in the dental chair? ☐ very good ☐ good ☐ poor ☐ very poor

What are your child's interests and/or hobbies? _____

Is there anything you would like to discuss with the doctor in private only? _____

Consent

Is it OK to take x-rays: _____

Is it OK to apply fluoride treatment: _____

Consent for Dental Treatment

I request and authorize Dr. Bender or any other dentist in the office 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. Bender to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or my 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. Bender 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 agree to pay all charges not covered by dental insurance. I further agree that I am permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for the dental treatment of this child.

_____ _____ _____

Signature **Relationship to Patient** **Date**