



Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Larry Caldwell, D.D.S.
& Associates



Tell Us About Your Child

Person Responsible for Account

Today's Date _____

Name _____
Last First MI

Preferred Name _____ Male Female

Child's Birth date ___/___/___ Child's Age _____

School _____ Grade _____

Child's Home# _____

Child's Home Address _____

_____ Apt/Condo# _____

City State Zip

Name _____

Billing Address _____

Work# _____ Ext ___ Home# _____

Employer _____

DL# _____ SS# _____

Name of Nearest Relative

Name _____

Work# _____ Ext ___ Home# _____

Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

Is your child adopted? Yes No

How did you hear about our office? _____

Other family member(s) seen by us _____

Parent's Marital Status Single Widowed
 Married Divorced
 Separated

Mother's Information Step-Mother Guardian

Name _____

Work# _____ Ext ___ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

Father's Information Step-Father Guardian

Name _____

Work# _____ Ext ___ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

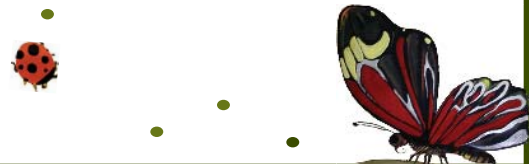
Relationship to Patient _____

Insured's Birth date ___/___/___ SS# _____

Insured's Employer _____

Orthodontic Coverage? Yes No

So that we may better serve you, please provide us with an email address: _____





Medical History



Reason for today's visit _____

Has the child ever had a bad experience with dental work? Yes No

Is the child **Delayed Average Advanced** in social development? Please circle one.

How would you describe the child's personality/temperament? Circle all that apply:

Cooperative Uncooperative Sensitive Apprehensive Well-adjusted Aggressive Shy

Previous dentists' name and phone number _____

Last Date Seen _____ X-rays _____

Is your child's drinking water fluorinated? Yes No

Is your child taking vitamins with fluoride supplements? Yes No

How many times a day are your child's teeth brushed? _____

Is the child currently using a bottle? Yes No How often? _____

Current dental habits. Please circle: **Thumb or Finger Sucking Use of Pacifier Lip or Cheek Biting Nail Biting**

Previous or current TMJ (jaw) pain, tenderness or popping? _____

Does the child have or ever had recurring headaches? Yes No

Has the child ever had any of the following medical problems? Please circle all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Tumors | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Sight Impairments |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defects | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Or Kidney Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Lung or Respiratory Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastro Intestinal Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Endocrine System | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairments |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Infections | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | |

History of blood transfusions? Yes No Date _____

Does the child have a heart murmur or condition that requires Prophylactic Antibiotic coverage for dental work?
 Yes No

Please list any serious medical problems that the child has had _____

Hospitalizations or injuries _____

Please list all drugs the child is allergic to _____ Other allergies _____

Please list all drugs the child is currently taking _____ Dose _____

Does the child have seizures? Yes No Are the seizures related to high fever? Yes No

Does the child experience an aura before seizure? Yes No Are the seizures related to high fever? Yes No

Does the child have any behavioral or learning disabilities? _____

Mental Retardation? Yes No Skill Level _____

Handicaps/Physical Disabilities _____

Any other significant problems or comments _____

Has the child had any recent infections of bacterial or viral origin? Yes No

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

Child's Physician _____ Phone _____ Date Last Seen _____

Because your child is a minor, it is necessary that signed permission be obtained from a parent or guardian before any/or all necessary dental treatment is performed. Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered. Your signature authorized Dr. Caldwell and/or his Pediatric Dentist Associate to render necessary dental treatment, to administer anesthetics, to administer medication, to take radiographs (X-rays), clinical photographs, study models and other records necessary for an accurate diagnosis, to utilize behavior management therapy as needed to provide safe dental care for your child and employ such assistance as is appropriate.

Signature of parent or guardian _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CEC and the ADA.

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. Initials ____ Date _____

Doctor's Comments _____