Dr. Duga Dr. Feeney & Associates
Pediatric Dentistry
preventive dental care for infants, children and teens

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Print Form

The following information and history are necessary for adequate treatment and understanding of your child. Thank you for completing it in full.

Patient's Full Name Nickname Age Yr Mo

Sex Race Date of Birth Social Security #

Patient's Address City State Zip

Home Phone E-mail Address:

School

Father's Full Name Social Security #

His Address City State Zip Ph

Date of Birth Cell Phone

Where Employed Phone

Mother's Full Name Social Security #

Her Address City State Zip Ph

Date of Birth Cell Phone

Where Employed Phone

Phone numbers for confirmation of appointment

With whom does patient live

Other children in family - names and ages

Dental Insurance? Company Policy #

Company Policy #

Child's Physician Family Dentist

Who may we thank for referring you to our office?

Doctor Parent Patient

Address if known City State Zip

Health History

Is your child taking vitamins or fluorides? Brand or type:

Do you have fluoride in your water system? Source of drinking water: (City, Well, etc)

Is your child in good health?

Does your child have regular medical examinations? Date of last exam:

Is your child up to date with immunizations?

Is this your child's first visit to the dentist?

Is your child a thumb / finger sucker?

Does your child use a pacifier?

At what age was nursing, bottle feeding or sippy cup discontinued?

How often are the child's teeth brushed each day?

Check any of the following that may pertain to your child:

- Rheumatic fever
- Heart condition
- Speech disorder
- Hearing disorder
- Vision disorder
- Nervous disorder
- Bleeding disorder
- Cerebral palsy
- Liver problem
- Kidney problem
- Asthma
- Endocrine disorder
- Cancer, tumors, blood disorders
- Lung problem
- Brain injury
- Epilepsy
- Hepatitis
- Diabetes
- Leukemia
- Bacterial or viral infections
- Recurrent headaches
- Retardation
- Behavioral/learning problem
- Mental disorder
- Emotional disorder
- Sickle Cell Anemia
- Autism
- Night grinding or TMJ problems
- Congenital birth defects
- HIV +
- Seizures
- Pneumonia
- Heart murmur
- Injury to teeth or mouth
- Blood Transfusion: (including at birth) Approximate Date

If yes to any, please explain:

Is your child presently taking any medication? (IF YES, list medications)

Is your child allergic to anything? (IF YES, list allergies)

Has your child experienced any unfavorable reaction to medicine? (IF YES, list medications)

Is your child presently undergoing medical treatment? (IF YES, list treatments)

Has your child ever been hospitalized since birth? (IF YES, list date and reason)

Has your child ever had an unfavorable experience in a dental office?

Date of your child's last dental care: Were X-Rays taken? Does your child have a toothache?

Purpose of appointment:

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment:

Your child is a minor, therefore, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. Restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health or his/her medications change, I will inform the doctor at the next appointment without fail. I realize that the parent bringing the patient to the office is responsible for payment of the account and I will be responsible for the cost of this dental care. In the event of default, I agree to pay a reasonable collection and/or attorney fee. Accounts may be subject to a 1.5% monthly service charge on balances 60 days or more past due. Accounts may be subject to a $50 charge for missed or broken appointments.

Date

_____

Signature of person completing form and responsible for payment of account

_____ Dental Assistant reviewing history _____ Doctor

MEDICAL HISTORY