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We're in the Business of Children's Smiles

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Specializing in Pediatric Dentistry



Today's Date ____ / ____ / ____

Patient's Name _____ DOB ____ / ____ / ____

Address _____ Age _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Email Address _____

Any changes to insurance since last visit? Yes No

If yes, please list change: Carrier _____ Subscriber _____

Subscriber's Date of Birth ____ / ____ / ____ ID# _____

Please describe any changes in your child's medical history since your last visit: _____

We are aware that some insurance companies only cover topical fluoride treatments once a year. However, the Academy of Pediatric Dentistry recommends this treatment be administered 1 time every 6 months, along with a child's cleaning appointment. If your insurance company fails to cover this procedures, you will be responsible for payment. Please indicate if you prefer this treatment today. Yes No

I, being the parent/guardian of the above minor patient, do hereby authorize the performance of routine dental services for this patient. This includes dental examination of hard and soft tissue, cleaning, fluoride (if applicable), check and repair sealants (if applicable), and necessary radiographs. I agree to be responsible for all changes for dental services and materials not paid by my dental plan. Yes No

Has your child ever had any of the following medical problems? (Circle appropriate response)

- Y N Allergies Y N Bronchitis Y N Hearing Impairment
Y N Anemia or Blood Disorders Y N Cancer/Chemotherapy Y N Heart Murmur
Y N Asthma or Hay Fever Please indicate type and current medications: _____ Y N Cerebral Palsy Y N Hepatitis, Liver Problems
Y N Autism Y N Congenital Heart Defect If yes, are Premed needed? Y N Y N HIV/AIDS
Y N Bladder/Kidney Problems Y N Convulsions/Seizures, Fainting or Epilepsy Y N Learning Disorder
Y N Bleeding/Bruises Easily Y N Childhood Illnesses Y N Psychological, Emotional Problems
Y N Blood Transfusion Y N Diabetes Y N Rheumatic Fever
Y N Blood Pressure, High/Low Y N Down Syndrome Y N Speech Disorder
Y N Handicap, Disabilities Y N Tuberculosis

List any drugs or medications child is currently taking: _____

Are child's immunizations current? Yes No Please explain: _____

Does your child have any special needs or special circumstances? (i.e., Autism, Cerebral Palsy, Down Syndrome) _____

Signature of Parent/Guardian _____ Date ____ / ____ / ____

Relationship to Patient _____

Name _____ Date _____

Oral Hygiene _____ Cooperation 1 2 3 4

XRays Completed _____ Caries Risk Assessment Low Moderate High

BRUSHING _____

FLOSSING _____

DRINKS _____

FACIAL PROFILE

Straight Convex Concave

TMJWNL

MOLAR RELATIONSHIP

Permanent	R	L	Primary	R	L
End-to-End	<input type="checkbox"/>	<input type="checkbox"/>	Terminal Plane	<input type="checkbox"/>	<input type="checkbox"/>
Class I	<input type="checkbox"/>	<input type="checkbox"/>	Straight	<input type="checkbox"/>	<input type="checkbox"/>
Class II	<input type="checkbox"/>	<input type="checkbox"/>	Mes. Step	<input type="checkbox"/>	<input type="checkbox"/>
Class III	<input type="checkbox"/>	<input type="checkbox"/>	Dist. Step	<input type="checkbox"/>	<input type="checkbox"/>

CANINE RELATIONSHIP

Class _____ R _____ L _____

INCISOR RELATIONSHIP

Overjet _____ mm
Overbite _____ %
Openbite _____

MIDLINE: Normal Deviates

XRays _____

R L

Maxilla mm _____
Mandible mm _____
Mandibular Shift No Yes
 mm _____

ARCH LENGTH (general impression)

Maxilla	Mandible
<input type="checkbox"/> Adequate	<input type="checkbox"/> Adequate
<input type="checkbox"/> Inadequate	<input type="checkbox"/> Inadequate

ANALYSIS RECOMMENDED

Yes No In Treatment
 Future _____

Related Findings: (Describe Abnormalities)

Eruption Sequence WNL Abnormal
Ankylosed Teeth No Yes
Crossbite No Yes
Oral Habits No Yes:

Supernumerary Teeth No Yes

Congenitally Missing Teeth No Yes

Ectopic Eruption No Yes

Intraoral _____ Buccal Mucosa WNL _____
Abnormal _____

Frenum Normal Heavy

Tongue WNL Abnormal

Palate WNL Abnormal

Gingiva WNL Abnormal

Other Abnormalities _____

TRAUMA No Yes

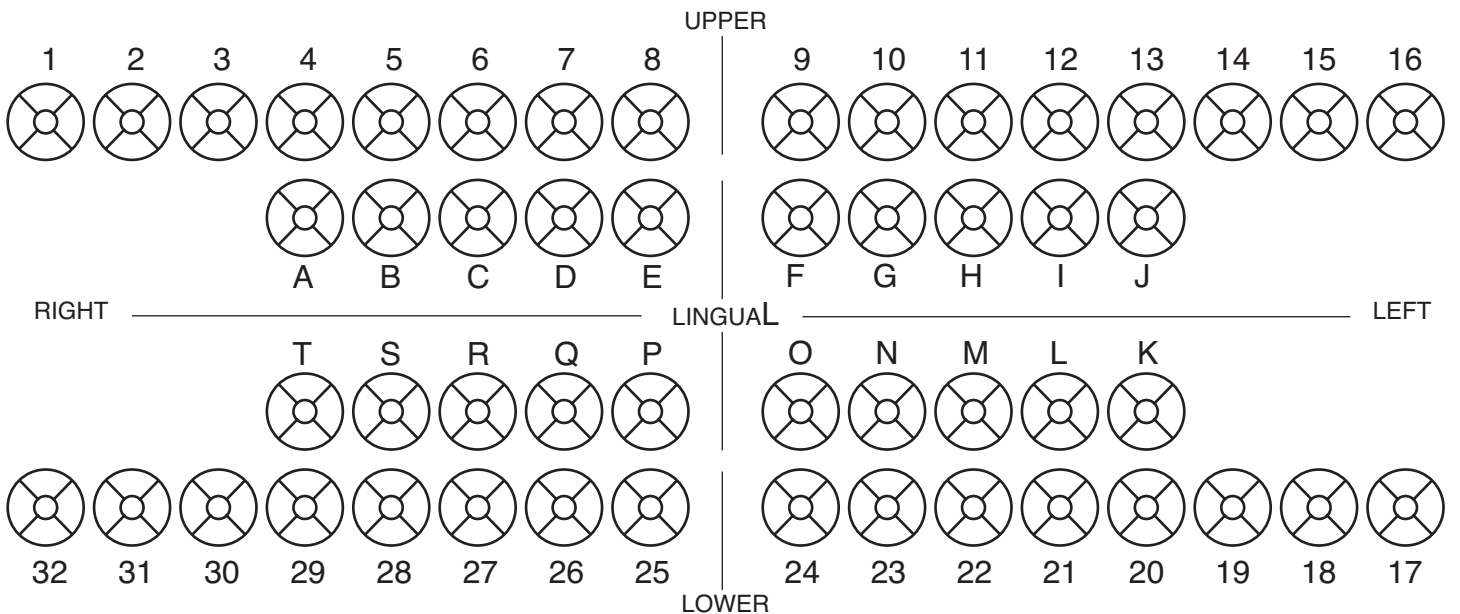
ENAMEL DEFECTS No Yes

DISCOLORATION No Yes:

FLOUROSIS No Yes

DIASTEMA No Yes

Polished _____ Scaled _____



NOTES: _____