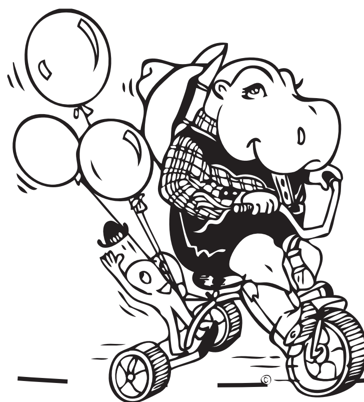
Alexandria **pediatric** Dentistry



richard r. brasher, d.d.s.

anna brasher moreau, d.d.s., m.s.

jennifer drummond finney, d.d.s.

PATIENT HEALTH INFORMATION

Child's name: ____________________ Sex: __________

Nickname: ____________________ Age: ________ Birth Date: __________

Does your child have a health problem? Yes ❑ No ❑

If yes, please list: ____________________

Does your child take any medicine(s) regularly? Yes ❑ No ❑

Name of medication	Dosage	Reason

Is your child allergic to penicillin? Yes ❑ No ❑

Other drugs? Please list: ____________________

Has your child ever been hospitalized or had any surgical procedures? Yes ❑ No ❑

When? ____________________

Reason? ____________________

Has your child had any history of the following or currently being treated for:

❑ ADD/ADHD
❑ Allergies
❑ Anemia
❑ Asthma
❑ Bleeding Disorder
❑ Cardiac Issues/Heart Murmur
❑ Cleft lip or palate
❑ Diabetes
❑ Dyslexia
❑ Emotional Issues
❑ Epilepsy/Seizures
❑ Handicaps/Disabilities
❑ Hearing Impairment
❑ HIV/AIDS
❑ Kidney/Liver Issues
❑ Lung disease
❑ Rheumatic/Scarlet Fever
❑ Speech Problems
❑ Tuberculosis

Has your child been tested for or diagnosed with any neurological disorders? Yes ❑ No ❑

❑ Autism ❑ Asperger's Syndrome ❑ PDD ❑ Sensory Intergration Disorder

Other: (Please list) ____________________

Please explain briefly why you brought your child for dental care: ____________________

____

Is this your child's first visit to the dentist? Yes ❑ No ❑ If no, how long since last dental visit? __________

Has your child had any unfavorable dental experience? Yes ❑ No ❑

Does your child have a toothache now? Yes ❑ No ❑

Does your child suck his thumb or finger(s)? Yes ❑ No ❑

Does your child have a pacifier, nursing bottle or sipper cup habit? Yes ❑ No ❑

Have there been any injuries to teeth, falls, blows, chips, etc. Yes ❑ No ❑

Consent for Treatment of a Minor

The undersigned hereby authorizes Alexandria Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental servies using methods deemed appropriate for the care of the above-named child. This consent shall remain in full force and effect until cancelled by either party. I understand that I am responsible for notifying this office of any accidents, major illnesses, or changes in medical history of the above named child.

Signed ____________________ Date __________ Relationship to Child __________

Who is accompanying this child today? ____________________ Relationship to Child __________

Do you have legal custody of this child? ____________________

Is the child adopted? Yes ❑ No ❑