alexandria pediatric dentistry

anna brasher moreau, d.d.s., m.s.
board certified pediatric dentist

patient health information

Child's name: ______________________________ Sex: __________
Nickname: ______________________ Age: ______ Birth Date: __________
Does your child have a health problem? O Yes O No
If yes, please list: ______________________________
Does your child take any medicine(s) regularly? O Yes O No

Name of Medication	Dosage	Reason

Is your child allergic to penicillin? O Yes O No
Other drugs? Please list: ______________________________

Has your child ever been hospitalized or had any surgical procedures? O Yes O No
When? ______________________________
Reason? ______________________________
Has your child had any history of the following or currently being treated for:

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

Has your child been tested for or diagnosed with any neurological disorders? O Yes O No
O Autism O Asperger's Syndrome O PDD O 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? O Yes O No If no, how long since last dental visit? __________
Has your child had any unfavorable dental experience? O Yes O No
Does your child have a toothache now? O Yes O No
Does your child suck his thumb or finger(s)? O Yes O No
Does your child have a pacifier, nursing bottle or sipper cup habit? O Yes O No
Have there been any injuries to teeth, falls, blows, chips, etc.? O Yes O No

consent for treatment of a minor

The undersigned hereby authorizes Alexandria Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services 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? O Yes O No
Is the child is adopted? O Yes O No