MONROE STREET FAMILY DENTAL

Child Patient Form

Today's Date:

Patient Name: Nickname: DOB: Gender: ☐ Male ☐ Female
SSN: Ins. ID: Address: Child lives with:

If the Child does not live with both parents, please provide the name & address of both parents below.

Mom:

Dad:

Who is accompanying the Child today? Name: Relationship to the Child:

DENTAL HISTORY

Any current dental complaints?

Has the child ever had a problem associated with previous dental work? ☐ Yes ☐ No
Explain:

Is the Child's water fluoridated? ☐ Yes ☐ No

Is the Child taking a fluoride supplement? ☐ Yes ☐ No

Does the Child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Is this the Child's first dental visit? ☐ Yes ☐ No
If no, who was their previous Dentist?

Last Visit Date:

ORAL HABITS

Currently using a bottle? ☐ Yes ☐ No
If no, what age discontinued?

Currently breast-feeding? ☐ Yes ☐ No
If no, what age discontinued?

Thumb/finger sucking? ☐ Yes ☐ No
Notes:

Nail biting? ☐ Yes ☐ No
Notes:

Lip sucking/biting? ☐ Yes ☐ No
Notes:

Speech Impairment? ☐ Yes ☐ No
Notes:

MEDICAL HISTORY

Does the Child have any current health problems? ☐ Yes ☐ No
If yes, please describe:

Is the Child under a Physician's care now? ☐ Yes ☐ No
If yes, please describe:

Family Physician: Ph #:

Does the Child have pins or screws anywhere in their body? ☐ Yes ☐ No
If yes, please list where:

What medications is the Child currently taking?

Check any of the following which the Child has had, or presently has:

☐ Heart Disease or Attack	☐ Diabetes	☐ Blood Transfusion	☐ Tuberculosis (T.B.)
☐ High Blood Pressure	☐ Kidney Trouble	☐ AIDS/HIV Positive	☐ Allergies or Hives
☐ Heart Pacemaker	☐ Tumor Malignancy	☐ Drug Addiction	☐ Venereal Disease
☐ Stroke	☐ Radiation Treatment Conditions	☐ Hay Fever	☐ Fever Blisters
☐ Artificial Heart Valve	☐ Chemotherapy	☐ Thyroid Disease	☐ Glaucoma
☐ Heart Murmur	☐ Liver Disease	☐ Nervousness	☐ Asthma
☐ Mitral Valve Prolapse	☐ Hepatitis	☐ Artificial Joints (hip, knee)	☐ Epilepsy or Seizures
☐ Arthritis	☐ Bleeding Problems	☐ Cortisone/Steroid Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Bruise Easily	☐ Ulcers	
☐ Chest Pain	☐ Anemia	☐ Psychiatric Treatment	

Please describe any marked above:

Is the Child allergic to or has the Child reacted adversely to any of the following?

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Nickel/other metals ☐ Nitrous Oxide ☐ Codeine
☐ Sulfa ☐ Penicillin ☐ Latex

Are you aware of the Child being allergic to any other medications or substances? ☐ Yes ☐ No
If yes, please list:

Is there any other Medical or Dental information regarding the Child that you feel I should know about?

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, and/or other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

Your Signature: Date:

FINANCIAL POLICY

Payment is due when services are rendered. Monroe Street Family Dental accepts cash, personal checks and all major credit cards. MSFD realizes that some procedures are more extensive than others and is more than willing to work out alternative financial arrangements prior to treatment.

I understand and agree that, regardless of my insurance or marital status, I am ultimately responsible for the balance on this account for any professional services rendered. I have read the above information and understand my obligations.

Signature of financially responsible party: Date: