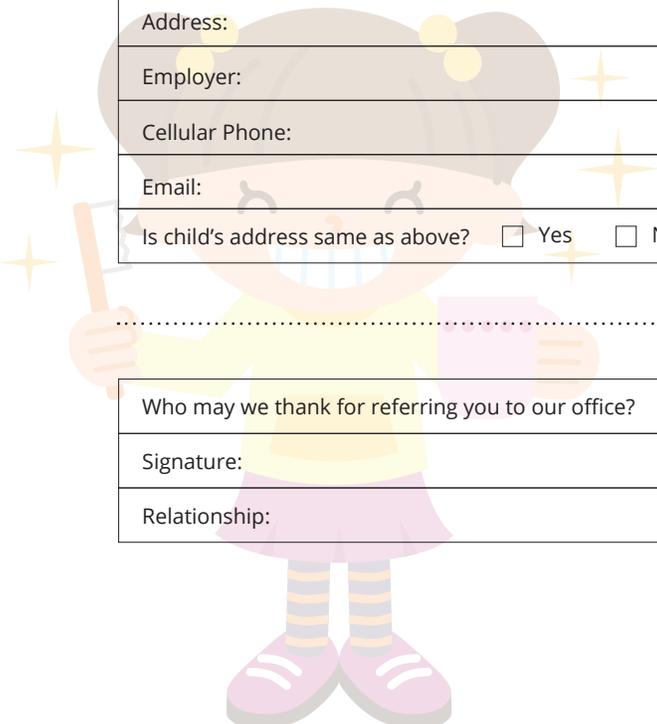


CHILD / CHILDREN'S NAME(S)	
Child Name:	Child DOB:

MOTHER'S INFORMATION	
Name:	<input type="checkbox"/> <i>Step-Mother</i>
DOB:	<i>Marital Status:</i>
Address:	
Employer:	<i>Occupation:</i>
Cellular Phone:	Alt Phone:
Email:	
Is child's address same as above? <input type="checkbox"/> Yes <input type="checkbox"/> No:	<input type="checkbox"/> <i>Responsible Party</i>

FATHER'S INFORMATION	
Name:	<input type="checkbox"/> <i>Step-Father</i>
DOB:	<i>Marital Status:</i>
Address:	
Employer:	<i>Occupation:</i>
Cellular Phone:	Alt Phone:
Email:	
Is child's address same as above? <input type="checkbox"/> Yes <input type="checkbox"/> No:	<input type="checkbox"/> <i>Responsible Party</i>

Who may we thank for referring you to our office?	
Signature:	<i>Date</i>
Relationship:	



PRENATAL, MEDICAL & DENTAL HISTORY

1. Were there any medical events during pregnancy (ex: pre-term labor, pre-eclampsia, high blood pressure)

No Yes, please explain:

2. Were any medications taken during pregnancy? No Yes, please explain:

3. Was the pregnancy full term? No Yes

4. Was birth natural or C-section? Natural C-section, please circle one: (emergency / scheduled)

5. Is this your first child? Yes No, birth order:

6. Did your child stay in the NICU? No Yes, please explain if there was oral or nasal intubation:

7. Did your child experience any chronic ear infections or fevers between 1-2 years old? No Yes

If yes, how many:

7a. Did your child have ear tube surgery? No Yes

7b. Did your child have their tonsils and adenoids removed? No Yes

8. Does your child have allergies? No Yes, please explain:

9. Was your child breast fed or formula fed? Formula Fed Breast fed - Any issues:

10. Does your child have any prior or current habits (ex: pacifier, bottle, thumb sucking)?

No Yes, please explain:

11. Does your child have any of the following conditions?

- | | |
|-----------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Sensory/Processing Disorder |
| <input type="checkbox"/> Any Hospital Stays or Operations | <input type="checkbox"/> Hepatitis/HIV/AIDS |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Cancer/Leukemia/Blood Disorder |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Handicaps/Disabilities/Special Needs |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver/Kidney Condition |
| <input type="checkbox"/> Asthma/Reactive Airway Disease | |

11. Please list all drugs patient is currently taking:

12. Is this your child's first visit to the dentist? Yes No, how long since last visit:

13. Were there any x-rays taken at the last dental visit? No Yes

14. Have there been any injuries to your child's teeth/mouth/face? Is your child in any pain?

No Yes, please explain

15. Is your child taking any supplements? No Yes

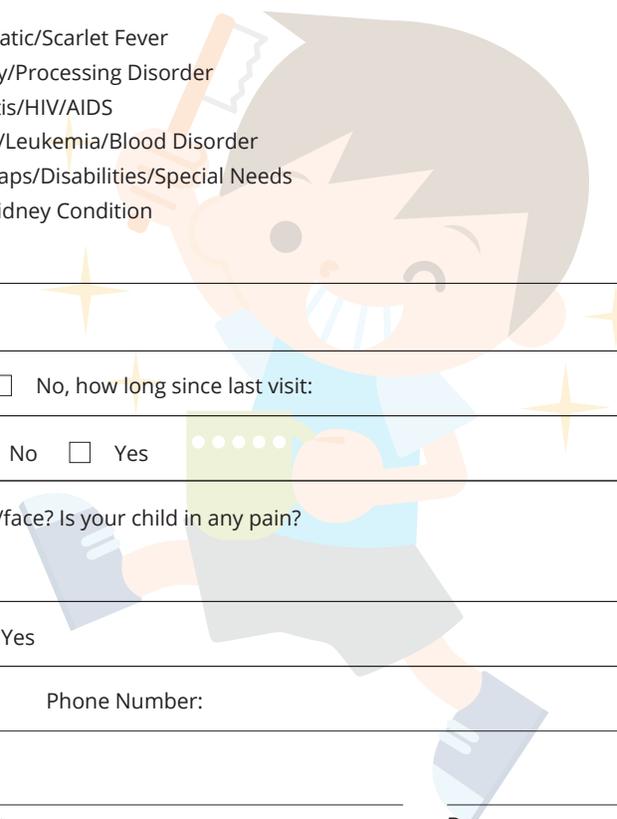
16. Name of Pediatrician:

Phone Number:

I agree and understand that I am accompanying the child and I am financially responsible for this visit:

Signature

Date



DIET & EATING HABITS

1. What are your child's eating habits? <input type="checkbox"/> Picky <input type="checkbox"/> Sit Down <input type="checkbox"/> Grazer
2. Please list some food your child normally eats: <input type="checkbox"/> Dairy <input type="checkbox"/> Dried Fruits <input type="checkbox"/> Pasta <input type="checkbox"/> Sticky Carbs <input type="checkbox"/> Whole Fruits & Veggies
3. What does your child mainly drink? <input type="checkbox"/> Water <input type="checkbox"/> Other
4. Is most of your child's food home cooked? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. How much processed food does your child eat? <input type="checkbox"/> Very minimal <input type="checkbox"/> 50% <input type="checkbox"/> More than 50%
6. Is your child still nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

BROKEN APPOINTMENTS

Since we set aside a special time in our schedule for your appointment, we kindly ask that if you are unable to keep your appointment please contact us 2 (two) business days in advance. Unfortunately if we do not receive advance notice, you will incur a minimum broken appointment charge of \$55 per appointment.

Most importantly, please keep us informed of any insurance changes such as policy name, insurance company address, or change in employment.

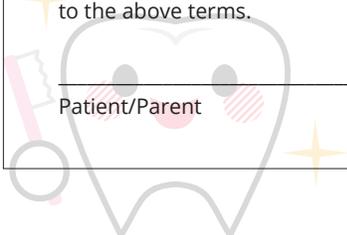
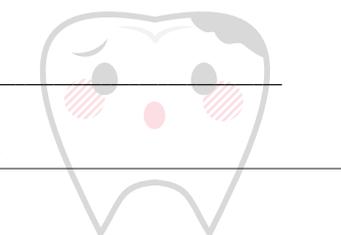
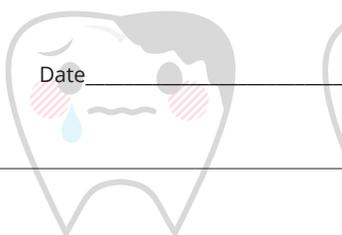
Patient/Parent Date _____

MODEL RELEASE

At Palm Beach Pediatric Dentistry we would like to share your positive experience via photo/video! We love sharing our patient's smiles with others and we appreciate your participation.

I hereby release, discharge and agree to hold harmless the practice of Palm Beach pediatric Dentistry, PA, their legal representatives or assigns, and all persons acting under their permission or authority, from any liability. I hereby warrant that I have read the above authorization, prior to its execution, and I am fully familiar with the contents thereof.

*Please sign below if you give permission for your child's photo/video to be shared and you understand and agree to the above terms.

			
Patient/Parent		Date	