

Laura Adelman D.M.D., Inc.  
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### Demographic Information

Today's date _____ Child's name _____ Child's preferred name _____ Date of Birth _____ Age _____ Male <input type="checkbox"/> Female <input type="checkbox"/> Home address _____ _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Street</span> <span>City</span> <span>Zip code</span> </div>		
<input type="checkbox"/> <b>Father</b> <input type="checkbox"/> <b>Step</b> <input type="checkbox"/> <b>Guardian</b> <b>Name:</b> _____  SS# _____  Father's B-day: _____  Home Ph: _____  Cell Ph: _____  Work Ph: _____ May we call you @ work? Yes / No  Employer: _____  Email: _____ _____ OK to confirm appointments at above E-mail? YES/NO	<input type="checkbox"/> <b>Mother</b> <input type="checkbox"/> <b>Step</b> <input type="checkbox"/> <b>Guardian</b> <b>Name:</b> _____  SS# _____  Mother's B-day: _____  Home Ph: _____  Cell Ph: _____  Work Ph: _____ May we call you @ work? Yes / No  Employer: _____  Email: _____ _____ OK to confirm appointments at above E-mail? YES/NO	<p style="text-align: center;"><b>Marital Status:</b></p> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> <b>Child resides with</b> <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Both  <b>Who is accompanying the patient?</b> _____  Is your child adopted? _____  Is your child in foster care? _____  Whom may we thank for referring you to our practice? _____ _____

**The parent/relative or guardian that accompanies a child for his/her appointment will be responsible for any payment at time services are rendered. Reimbursement must be made between divorced parents. Our office will not intervene.**

### Insurance Information

<b>Yes / No Dental Insurance</b>	<b>Subscriber</b> _____
Dental Insurance Co.: _____ Ph. # _____	
Insurance Co. Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>City</span> <span>State</span> <span>Zip</span> </div>	
Employer: _____	Group Number: _____
Employer Address _____	

# Health History

**Yes/No** Is your child in good health? Date of last medical checkup \_\_\_\_\_

Name of child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**Yes/No** Were there any problems at birth? \_\_\_\_\_

**Yes/No** Has your child ever had any health problems? \_\_\_\_\_

**Yes/No** Has your child ever been hospitalized/Surgeries? If so, list why and date: \_\_\_\_\_

**Yes/No** Is your child currently taking any medication? If so, please list \_\_\_\_\_

**Yes/No** Does your child have any food allergies? Please list \_\_\_\_\_

**Yes/No** Is your child allergic to any medications? \_\_\_\_\_

## Is your child allergic to any of the following?

- |                                     |                                  |                                  |   |                                       |
|-------------------------------------|----------------------------------|----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Latex   | <input type="checkbox"/> Codeine | <input type="checkbox"/> Metals             | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Sulfa   | <input type="checkbox"/> Dental Anesthetics | <b>Other</b> _____                    |

## Please check if your child has been treated for any of the following:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Autism                      | <input type="checkbox"/> Rheumatic/Scarlet Fever   | <input type="checkbox"/> Hepatitis A                 |
| <input type="checkbox"/> Blood Disorders       | <input type="checkbox"/> Cerebral Palsy              | <input type="checkbox"/> Congenital Birth Defect   | <input type="checkbox"/> Hepatitis B or C            |
| <input type="checkbox"/> Bleeding/Transfusions | <input type="checkbox"/> Cleft Lip/Palate            | <input type="checkbox"/> Heart Defect (Congenital) | <input type="checkbox"/> AIDS/HIV+                   |
| <input type="checkbox"/> Bruise Easily         | <input type="checkbox"/> Development Delays          | <input type="checkbox"/> Heart Murmur (MVP)        | <input type="checkbox"/> Kidney disease              |
| <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Handicap/physical delays    | <input type="checkbox"/> Heart Valve (Artificial)  | <input type="checkbox"/> Liver disease               |
| <input type="checkbox"/> Sickle Cell Disease   | <input type="checkbox"/> Speech/Hearing Impaired     | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Cancer/ Chemo/<br>Radiation |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Visually Impaired (Glasses) | <input type="checkbox"/> Frequent Infections       | <input type="checkbox"/> Epilepsy                    |
| <input type="checkbox"/> ADHD                  | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Fever Blisters/Cold Sores | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Asperger's Syndrome   | <input type="checkbox"/> Seasonal Allergies          | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Thyroid<br>Problems         |

**Please elaborate on ANY items marked:** \_\_\_\_\_

Do you consider your Child to be: \_\_\_advanced in the learning process

\_\_\_ progressing normally

\_\_\_ delayed in the learning process

**Yes/No** Is your child shy?      **Yes/No** Does your child **adjust well to new situations**?

Do you have any other concerns or is there anything else significant about your child that you would like to mention?

\_\_\_\_\_

\_\_\_\_\_

## Dental History

**Yes/No** Has your child ever been to the dentist? If yes, name of dentist and date \_\_\_\_\_

**Yes/No** Has your child had **dental x-rays** taken? If yes, approximate date \_\_\_\_\_

**Yes/No** Has your child had **local anesthesia** (novocaine)?

**Yes/No** Has your child had nitrous oxide during a dental procedure?

**Yes/No** Has your child experienced any unfavorable reaction from previous dental care?

Please explain \_\_\_\_\_

**Yes/No** Does/Did your child suck a finger, thumb or pacifier? **Which one:** \_\_\_\_\_

What **age did they stop?** \_\_\_\_\_

Was your child: **Breast fed** \_\_\_\_ **Bottle fed** \_\_\_\_ At what age was it stopped? \_\_\_\_\_

**Yes/No** Is your home water supply fluoridated?

**Yes/No** Does your child use toothpaste containing fluoride?

**Yes/No** Do you give your child any other form of fluoride? What? \_\_\_\_\_

**Yes/No** Does your child have pain with chewing, yawning, or wide opening?

**Please check if your child is having problems with any of the following:**

- |   |   |  |                                     |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Cavities       | <input type="checkbox"/> Toothache      | <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Trauma     |
| <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of Teeth | <input type="checkbox"/> Orthodontics    | <input type="checkbox"/> Jaw Sounds |

**Comments:** \_\_\_\_\_

## Family Medical & Dental History

Which member in the **immediate** family has a history of:

**Allergies:** Mom / Dad / Sibling Allergic to what: \_\_\_\_\_

**High decay rate:** Mom / Dad / Sibling **No / Minimal dental decay:** Mom / Dad / Sibling

**Extra or missing teeth:** Mom / Dad / Sibling / Grandparent. Which did they have? **Extra**

**teeth / Missing teeth** **Had orthodontic treatment** (which member(s)? \_\_\_\_\_

Name of Orthodontist \_\_\_\_\_

## Consent for Dental Treatment

I request and authorize Dr. Laura Adelman to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Laura to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or education purposes. I understand that dental treatment for children include efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Laura will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_