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 □ Female □

Home address ____

____

Street City Zip code

□**Father** □**Step** □**Guardian**

Name: _________________

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

□**Mother** □**Step** □**Guardian**

Name: _________________

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

Marital Status:

Married □ Single □

Widowed □ Divorced □

Partnered □ Separated □

Child resides with

□ Mom □ Dad □ Both

Who is accompanying the patient? ________________

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

Yes / No Dental Insurance **Subscriber** ____________________________

Dental Insurance Co.: ________________________________Ph. #______________________

Insurance Co. Address: ____

City State Zip

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?

☐ Asprin	☐ Latex	☐ Codeine	☐ Metals	☐ Erythromycin
☐ Penicillin	☐ Jewelry	☐ Sulfa	☐ Dental Anesthetics	**Other**______________

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

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

□ Cavities	□ Toothache	□ Sensitive Teeth	□ Trauma
□ Gum Infections	□ Color of Teeth	□ Orthodontics	□ 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 ______________