

CHILDREN'S DENTAL HISTORY

1. Is this your child's first visit to the dentist? Yes No
2. When was the last visit to the dentist? _____
 What was done at that visit? _____
3. Has your child ever had a bad experience with a dentist? Yes No
4. Does your child take fluoride supplements or vitamins with fluoride? Yes No
5. Have there been any injuries to your child's teeth or jaws? Yes No
6. Has your child had any of the following dental problems?

Cavities	Yes	No	Sensitivity to:		
Tooth aches	Yes	No	Hot	Yes	No
Crooked teeth	Yes	No	Cold	Yes	No
Discolored teeth	Yes	No	Sweets	Yes	No
7. Has your child had any of the following habits?

Thumb sucking	Yes	No	Lip Biting	Yes	No
Nail biting	Yes	No	Finger biting	Yes	No
Pacifier	Yes	No	Bottle	Yes	No
8. What reason for your visit today? _____
9. Please list any questions or concerns you may have about your child's oral health:

Consent

I grant permission to Dr. Monroe to do all such things as are necessary to diagnose, treat, and care for the dental needs of my child. Treatment will not be preformed without first consulting the child's parent or legal guardian. All children (under age 18) must be accompanied by a parent or legal guardian for the duration of all their dental visits.

In order to give your child our full attention we request that you remain in the reception area while treatment is performed. If your child is not cooperative we may suggest sedation or referral to a pediatric specialist. However, you will be charged an office visit fee for the time spent with your child.

I understand that my insurance company may pay less than the actual bill for services and that I am fully responsible for payment of my account. By signing this statement I agree to pay for any and all services not paid, in whole or in part by my dental or medical care insurance/payor and any legal fees incurred to enforce this statement. I hereby authorize the release of any information relating to insurance claims for my child's dental services. I also authorize the payment of my group insurance benefits directly to Dayton Dental.

I certify that the information I have provided here is true and correct, and I understand and agree to the consent provisions.

Signature _____ Date _____

Printed Name _____ Relationship to Patient _____

Dentist's Signature _____