Patient_____

Birthday_____ Age_____ Sex _____

School_____ Home# _____

Guardian #1_____Mobile #_____

Relationship to Child_____ E-Mail _____

Address _____

Employer_____Work #_____

Guardian #2_____ Mobile# _____

Relationship to Child_____E-Mail _____

Address _____

Employer_____Work# _____

Who has legal custody of patient? _____

Name of Child's Physician _____Phone # _____

Health History

Is your child in good health? YES/NO Date of Last Physical Exam _____

Has your child ever had a health problem? _____

Has your child ever been hospitalized? Please give dates and reasons. _____

_____

Please list child's allergies

_____

_____

_____

Please list child's medications

_____

_____

_____

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

AIDS/HIV	Cancer/Tumors	Eyesight	MRSA
Adverse drug Reactions	Cerebral Palsy	Frequent Infections	Social Anxiety
Anemia	Cleft Lip/Palate	Heart Disease/Murmur	Seizures
Asthma/Breathing	Birth Defects	Hepatitis	Physical Delay
Autism/ Sensory	Diabetes	Kidney Disease	Liver Disease
Speech/Hearing	Down's Syndrome	Bleeding/Transfusion	Blood Disorder
Rheumatic Fever	Endocrine/Growth	Mental Delays	Other

Do you consider your child's learning process to be:

___Advanced ____Normal ___Slow

Was your child:(Please Circle) Breast Fed Bottle Fed

Has your child ever been to the dentist?_____ Date of last dental x-rays _____

Name of previous dentist:_____ Phone #_____

Has your child ever had a bad experience at the dentist? Explain _____

_____

Does your child suck a finger, thumb or pacifier? _____

Does your child have pain with chewing, yawning or wide opening? _____

Does your child's jaw make noise?_____ Does your child grind their teeth? _____

Does the child have well water?_____ Does the child use fluoridated toothpaste? _____

Please circle if your child is having problems with any of the following.

Cavities	Toothache	Teeth Sensitivity	Trauma
Gum Infections	Orthodontics	Jaw Sounds	Color of Teeth

Comments: _____

Consent for Dental Treatment

I request and authorize Lee Bass Nunn, DDS and/ or practicing associate 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 the dentist 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 educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Nunn and/ or practicing associate 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. In addition, I understand that although every effort is made to inform guardian of treatment needs, those needs sometimes change during treatment and authorize changes in treatment deemed necessary by Dr. Nunn and / or practicing associate.

Signature of Guardian _____ Date_____

Print Name of Guardian _____