

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 _____