CAROL A. FRENCH, D.M.D.

PEDIATRIC AND ADOLESCENT DENTISTRY
FAMILY HISTORY AND CONSENT FORM

DATE ____________________

CHILD'S SOCIAL SECURITY #: ____________________________________

CHILD'S NAME: ______________________________ (FIRST / MIDDLE / LAST) NICKNAME: ______________ SEX: ____ AGE: ________

BIRTHDATE: ________________________________ PLACE OF BIRTH: ______________________________

HOME ADDRESS: ______________________________ CITY: __________________ ZIP: __________

HOME PHONE: ________________ SCHOOL ______________________________ GRADE: __________

WHAT IS YOUR CHILD MOST INTERESTED IN? (Toy, Hobby, Activity) ______________________________

DO YOU HAVE A PET? TYPE AND NAME? ______________________________

NAME AND AGE OF BROTHER(S): ______________________________

NAME AND AGE OF SISTER(S): ______________________________

WHOM MAY WE THANK FOR REFFERRING YOU TO OUR OFFICE? ______________________________

ADDRESS, IF KNOWN: ______________________________

FATHER'S NAME: ______________________________ (FIRST / MIDDLE / LAST) SOCIAL SECURITY #: ________________

MOTHER'S NAME: ______________________________ (FIRST / MIDDLE / LAST) SOCIAL SECURITY #: ________________

FATHER'S DATE OF BIRTH: ________________ (MONTH / DAY / YEAR) MOTHER'S DATE OF BIRTH: ________________ (MONTH / DAY / YEAR)

MARITAL STATUS: MARRIED ________ SEPARATED ________ DIVORCED ________ OTHER: ________

FATHER EMPLOYED BY ______________________________ TITLE/OCCUPATION ______________________

ADDRESS ______________________________ BUS. PHONE ________________

MOTHER EMPLOYED BY ______________________________ TITLE/OCCUPATION ______________________

ADDRESS ______________________________ BUS. PHONE ________________

CLOSEST RELATIVE: NAME AND ADDRESS, NOT LIVING WITH YOU: ______________________________

______________________________ PHONE #: ________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: ______________________________

ADDRESS, IF DIFFERENT THAN CHILD'S: ______________________________

PAYMENT METHOD: ☐ CASH ☐ CHARGE CARD ☐ CHECK ☐ MEDICAID

NAME OF INSURANCE COMPANY ______________________________

If your child's treatment is covered in whole or part by a prepaid dental plan or dental insurance the completed dental insurance forms must be in my office before treatment begins. Payment is expected as services are rendered unless other financial arrangements have been made with the office in advance.

I, being the parent or legal guardian of ______________________________ authorize, request and permit Carol A. French, D.M.D. and any employees under her supervision to perform any and all manner of Dental-Medical treatment, services, and behavior management techniques that may be indicated in connection with my child, and to do whatever procedures that the judgement of the doctor may indicate during treatment. I understand that parents are allowed in the parent chairs during the child's treatment.

I further authorize and request the administration of such medication(s), anesthetic(s), analgesia(s) and the taking of such x-rays as may be deemed advisable by Dr. French, I further authorize Dr. French to use or take photographic illustrations and records to assist in improving dental diagnosis and treatment for the purpose of education and the advancement of learning.

The risks and nature of treatment have and shall continue to be explained to me as treatment progresses and no warranty or guarantee has been made as to the results or cure.

I assume responsibility for any and all charges incurred on behalf of my child for Dental-Medical treatment.

DATE: ____________________ SIGNATURE: ______________________________

WITNESS: ______________________________

CONFIDENTIAL HEALTH HISTORY

MEDICAL HISTORY

1. Child's pediatrician or physician: ____________________

   address: ____________________ phone #: ____________________

2. Is your child presently under a physician's care. ☐ yes ☐ no

   If yes, physician's name and nature of treatment ____________________

3. Date of last physical examination ____________________

4. Parent's opinion of child's present health: ☐ good ☐ poor

5. Is your child now taking any medication? What? Why? ____________________

6. How well did your child accept his past medical or dental care physician? ☐ good ☐ poor

7. Has your child ever been hospitalized? __________ Emergency room ____________________

   If yes, why? ____________________

8. Is your child taking any drugs or medication at this time? ☐ yes ☐ no

   Please list: ____________________

9. Has your child had any of the following? Explain

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS	☐	☐	BLOOD DISORDERS	☐	☐	FAINTING
☐	☐	ALLERGIES	☐	☐	BRAIN DAMAGE	☐	☐	HEART MURMUR (TYPE - PCN)
☐	☐	ANEMIA	☐	☐	CANCER	☐	☐	HEPATITIS
☐	☐	ARC	☐	☐	DIABETES	☐	☐	HEART CONDITIONS
☐	☐	ASTHMA	☐	☐	BIRTH DEFECTS	☐	☐	HEMOPHILIA
☐	☐	BLADDER DISEASES	☐	☐	EPILEPSY	☐	☐	HERPES
☐	☐	BLEEDING DISORDER	☐	☐	EYE PROBLEMS	☐	☐	HYPERACTIVITY
☐	☐	CEREBRAL PALSY	☐	☐	EAR INFECTIONS	☐	☐	HEARING PROBLEMS
☐	☐	CHICKEN POX	☐	☐	EMOTIONAL PROBLEMS	☐	☐	KIDNEY DISEASE
☐	☐	CHRONIC SINUS				☐	☐	LIVER PROBLEMS
☐	☐	CONVULSIONS				☐	☐	LUNG DISEASE
☐	☐	CYSTIC FIBROSIS				☐	☐	LEUKEMIA
☐	☐	COLD SORES				☐	☐	MALIGNANCIES
						☐	☐	MEASLES
						☐	☐	MOUTH ULCERS

YES	NO		YES	NO	
☐	☐	MONONUCLEOSIS	☐	☐	TRANSFUSIONS
☐	☐	MUMPS	☐	☐	TUBERCULOSIS
☐	☐	MENTAL RETARDATION	☐	☐	THYROID
☐	☐	RHEUMATIC FEVER	☐	☐	OTHERS, IF SO WHAT? _____
☐	☐	RESPIRATORY PROBLEMS			__________
☐	☐	SICKLE CELL DISEASE			__________
☐	☐	SICKLE CELL TRAIT			__________
☐	☐	SPEECH PROBLEMS			

10. Is your child allergic to anything? (ex. penicillin, codeine, novocaine, aspirin, demerol, local anesthesia, tylenol, xylocain, etc.)_

    ____

    If yes, what type of reaction did they experience? (ex. rash, itching, swelling, etc.) ____________________

11. If necessary, may we request release of your child's medical records for our reference? ☐ yes ☐ no

DENTAL HISTORY

1. Age first tooth appeared: ______________________
2. Age bottle feeding or breast feeding discontinued: ______________________
3. Has your child been to a dentist before? ☐ yes ☐ no Who? ______________________
   When? ______________________
   Why? ______________________
   Child's behavior? ______________________
4. Purpose of this visit: ______________________
5. Has any member of your family ever been treated in this office? ______________________
6. Does your child have or use any of the following? Please indicate with an (X).

( ) Traumatic injury to mouth or teeth?
When? ______________________
( ) Recent toothache
( ) Sensitivity to cold, hot, sweets, pressure
( ) Bleeding gums, for how long ______________________
( ) Food impaction
( ) Clenching or grinding teeth
( ) Swelling or lumps in mouth
( ) Frequent blisters on lips or mouth
( ) Pain around ears
( ) Bad Breath
( ) Complications from extractions
( ) Excessive bleeding ______________________
( ) Topical Fluoride Treatment
( ) Orthodontic Treatment
( ) Mouth breathing

( ) Oral habits: thumb sucking, nail-biting, pacifier, cheek biting, tongue thrusting
( ) Brushing frequency ________ x's/day
( ) Who brushes ☐ Child ☐ Parent
( ) Dental Floss
( ) Disclosing tablets/solution
( ) Fluoride supplements/vitamins
( ) Between meal snacks
( ) Well balanced diet
( ) Bed-time nursing bottle
( ) Chipped teeth
( ) Fluoridated water
( ) Any particular dental concerns:
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