SCOTT H. LEAF, D.D.S. Pediatric Dentistry
CAITLYN R. NUGER, D.D.S

I. GENERAL INFORMATION

A. Child's Name________________________ Nickname________________

B. Sex__________ Age__________ Date of Birth________________

C. Father's / Guardian's Name________________________________

D. Mother's / Guardian's Name________________________________

E. Home Address________________________________

F. City & State________________ Zip________ Home Phone________________

G. Cell Phone ________________ Email ________________________

H. Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Other

I. Person responsible for account________________________________

J. Father's / Guardian's Employment________________________________

Address________________________ Bus. Phone________________

K. Mother's / Guardian's Employment________________________________

Address________________________ Bus. Phone________________

L. Prior Dentist________________________ Phone________________

M. Who referred you to us?________________________________

N. Reason for bringing child to the dentist________________________

II. CHILD'S MEDICAL HISTORY

		Yes	No
A.	Childs Physician________________________	( )	( )
B.	Is your child being treated by the physician presently?	( )	( )
C.	Are your child's immunizations up-to-date	( )	( )
D.	Has your child ever been a patient in the hospital?	( )	( )
E.	Were there any complications before or during birth?	( )	( )
	Prematurity? **Y N** Birth Defects **Y N** Syndromes **Y N** Inherited Conditions **Y N**		
F.	Are there any problems with physical growth or development?	( )	( )
G.	Does your child have any allergies to any drug, food, metals, dyes or latex? If so what? ________________	( )	( )
H.	Is your child presently taking any medicines?	( )	( )
I.	Does your child have any difficulty in school?	( )	( )
J.	Does your child have any history of rheumatic fever, heart trouble, heart murmur, hepatitis, asthma, diabetes, kidney or liver involvement, mental retardation, blood disease or excessive bleeding, or brain damage? (If yes, please underline condition)	( )	( )
K.	Have you ever been told by your doctor that your child needs antibiotic prophylaxis before dental procedures?	( )	( )

III. CHILD'S DENTAL HISTORY

		Yes	No
A.	Has your child ever been seen by a dentist?	( )	( )
B.	Has you child experienced any unfavorable reaction from any previous dental or medical care?	( )	( )
C.	Is either parent subject to much tooth decay?	( )	( )
D.	Has your child ever had a local anesthetic?	( )	( )
E.	Does your child suck his fingers or thumb?	( )	( )
F.	Does your child have (or had) a toothache, sensitive teeth, teeth bumped, discolored teeth, bleeding gums? (If yes, please underline condition)	( )	( )
G.	Is your community water supply fluoridated?	( )	( )
H.	Have you ever given your child fluoride vitamins or tablets?	( )	( )
I.	Do you supervise your child's cleaning procedure?	( )	( )
J.	Does your child use dental floss?	( )	( )
K.	How often does your child brush daily?________________		
L.	What type of toothpaste is used?________________		

IV. PERMISSION

I (we) hereby give authorization as a parent or guardian to Scott H. Leaf, D.D.S.& Associates for the completion of all agreed upon dental services for my child or children, and agree to become personally responsible for such financial obligations incurred.

Signature________________________________

Parent/Guardian's Social Security Number________________

Parent/Guardian's Birthdate________________________

Date Signed ________________________