BLUE SPRUCE DENTAL

Kevin R. Timm, DDS

Child's Medical and Dental Information

Dentistry has changed significantly in the last few years and these new technologies require more information to treat you safely and completely. The following is important information about your child's physical and dental health as well as some questions about lifestyle. Your honest and complete answers allow us to serve you to the best of our ability.

Name_____ Birthdate_____ Social Security #_____

Mom's Name _____ Dad's Name _____

SS # _____ SS # _____

Address _____ Address _____

City, State, Zip_____ City, State, Zip _____

Home # _____ Work # _____ Home # _____ Work # _____

Cell # _____ DL # _____ Cell # _____ DL # _____

Email: _____ Email: _____

Emergency Contact _____ Phone # _____

Whom may we thank for referring you to our office: _____

General Health Information

Physicians Name_____ City_____ Phone_____

Last Physical Exam_____ Rate health Good / Fair / Poor

Is your child taking any medications or drugs (including Aspirin) YES / NO

Name of Medicine	Dosage	Times per day	Purpose

Allergies to: _____

Has your child ever been Premedicated for dental treatment? YES / NO Reason _____

Do you have any of the following? Check all that apply….

	Cancer		Neurological disorders		Rheumatic Fever		Measles
	Heart Murmur		Radiation/Chemotherapy		Diabetes		Mumps
	Heart Problems		Blood Transfusion		Kidney/Liver issue		Chicken Pox
	Asthma		Handicaps/disabilities		Hepatitis		Tuberculosis
	Epilepsy		Frequent headaches		AIDS/HIV		

Any disease, condition or problem not listed:_____

(OVER)

DENTAL INFORMATION

Name of Previous Dentist_____ City_____ Phone#_____

Date of Last Exam_____ Purpose_____

What did you like **best** about your previous Dentist?_____

What did you like **least** about your previous Dentist?_____

Are you aware of any dental problems? YES / NO Explain_____

Date of last Bitewing Xrays:_____ Date of last Full Series or Panorex?_____

Has your child ever had Braces? YES / NO Orthodontist Name_____

Has your child ever used Nitrous Oxide? YES / NO How did they like it?_____

Do they drink Pop or Sports Drinks? YES / NO Juice? YES / NO Amount per day_____

Do they or have they ever used tobacco products? YES / NO Type?_____ Amount?_____

Would your child be interested in whitening their teeth? YES / NO

Do they ever have a popping or clicking in their jaw? YES / NO

What would you consider your child's pain threshold to be: LOW AVERAGE HIGH

How nervous or worked up do they get during dental appointment? _____

Please rate the health of their mouth 1-10 (10 being best)_____ What do you want it to be?_____

What would you like to change about your child's smile?

Do you have any other comments or concerns we should know about?

Is there any other person who may bring child to appointments and have authority to approve treatment (please indicate relationship)? _____

_____

I understand that in order to receive the best care, I must do my part to help the doctor and answer these questions to the best of my ability. I certify that the above information is complete and accurate. If I have dental insurance, I realize that the full bill is my responsibility and authorize Dr. Timm to work as my agent to assist me in receiving payment from the insurance company.

Parent Signature_____ Date_____