JOHNSON & GENC DENTISTRY
FAMILY - COSMETIC - RECONSTRUCTIVE

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CHILD'S NAME_____

DATE OF BIRTH____/____/_____ **AGE**_____ **WEIGHT**_____**lbs.**

MALE____**FEMALE**____

SCHOOL OR DAYCARE NAME_____
NAME OF SIBLINGS_____

HOW DID YOU HEAR ABOUT OUR OFFICE_____

DENTAL HISTORY:

PURPOSE OF TODAY'S VISIT_____

DATE OF LAST EXAM_____**LAST X-RAYS**_____

ANY UNFAVORABLE DENTAL EXPERIENCES?_____

PLEASE (X) ANY WHICH APPLY TO YOUR CHILD:
_____ **INJURY TO MOUTH OR TEETH Explain**_____
_____**ORAL HABITS: Thumb/Finger sucking**_____ **Pacifier**_____ **Nail biting**_____
Tongue thrust_____
_____ **SENSITIVE/PAINFUL TEETH: Daytime**_____ **Nighttime**_____
_____ **GRINDING OF TEETH: Daytime**_____ **Nighttime**_____

FREQUENCY OF BRUSHING____**Times per day**_____ **DOES PARENT HELP** _____

MEDICAL HISTORY:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Circle one: Y= Yes, N=No

Y N	**HEART MURMUR**	**Y N**	**RHEUMATIC FEVER**
Y N	**CONGENITAL HEART DEFECT**	**Y N**	**CANCER/ TUMOR**
Y N	**DIABETES**	**Y N**	**KIDNEY/LIVER DISEASE**
Y N	**HIV VIRUS/AIDS**	**Y N**	**MENTAL HANDICAP**
Y N	**BLOOD DISORDER/TRANSFUSIONS**	**Y N**	**PHYSICAL HANDICAP**

Y N SICKLE CELL ANEMIA
Y N HEPATITIS/ JANDICE
Y N TUBERCULOSIS
Y N CONVULSIONS/EPILEPSY
Y N ASTHMA
Y N SINUS/ ALLERGY PROBLEMS
Y N HEARING IMPAIRMENT
Y N SPEECH IMPAIRMENT
Y N HYPERACTIVE/ ADHD/AUTISM
Y N HOSPITALIZATION
Y N SURGERY

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE OR OTHER PROBLEMS NOT LISTED:

_____

MEDICATIONS THE CHILD IS TAKING NOW?_____

MEDICATIONS OR FOOD THE CHILD IS ALLERGIC TO?_____

CHILD'S PHYSICIAN_____PHONE_____
PHYSICAN'S ADDRESS_____
DATE OF LAST EXAM_____
FAMILY ORTHODONTIST'S NAME_____CITY_____
HAS YOUR CHILD SEEN THE ORTHODONTIST? YES NO LAST EXAM_____
FAMILY MEMBERS WHO SEE THE ORTHODONTIST_____

EMERGENDY CONTACT (Relative or friend not living with you)
NAME_____

RELATIONSHIP TO PARENT_____PHONE_____

DENTAL INSURANCE IMFORMATION:

DENTAL INSURANCE COMPANY_____
GROUP NUMBER_____INSURANCE CO. PHONE_____
INSURED'S NAME_____ Soc. Security# or ID#_____

PARENT INFORMATION:

FATHER'S NAME_____**BIRTH DATE**___/___/___

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE_____**CELL**_____**WORK**_____

EMPLOYER_____**CITY**_____

MOTHER'S NAME_____**BIRTHDATE**___/___/___

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE_____**CELL**_____**WORK**_____

EMPLOYER_____**CITY**_____

CHILD'S PRIMARY RESIDENCE: FATHER MOTHER BOTH OTHER (see below)

If OTHER, name of caretaker and address

_____

_____

CONSENT FOR TREATMENT:

I certify that I am the parent/legal guardian of this child who is responsible for medical/dental decisions. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status at future appointments.

I authorize Dr. Kimberly Johnson Genc, Dr. Robert D. Genc and/or Dr. Paul Johnson, and staff to perform the necessary dental services for my child.

Signature_____Date_____