

KIDS TEETH

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FOR THE BENEFIT AND PROTECTION OF YOUR CHILD, WE NEED YOUR COOPERATION IN ANSWERING THE FOLLOWING QUESTIONS.

FATHERS AND MOTHERS NAME _____
HOME ADDRESS _____
HOME PHONE _____
FATHERS EMPLOYER _____ . SOC. SECURITY# _____
BUSINESS ADDRESS _____ BUS. PHONE _____
MOTHER'S EMPLOYER _____ SOC. SECURITY # _____
BUSINESS ADDRESS _____ BUS. PHONE _____
MARITAL STATUS: MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED _____ SINGLE _____
IN CASE OF EMERGENCY AND PARENT UNAVAILABLE. CALL _____
BEST TELEPHONE NUMBER TO CONFIRM APPOINTMENTS _____
EMAIL ADDRESS _____

THE PARENT OR GUARDIAN WHO BRINGS THE CHILD TO THE DENTAL APPOINTMENT IS RESPONSIBLE FOR THE ACCOUNT.

WHOM MAY WE THANK FOR REFERRING OR RECOMMENDING US? _____

CHILD'S NAME _____ **NICKNAME** _____

CHILD'S AGE _____ **BIRTHDAY: MONTH** _____ **DAY** _____ **YEAR** _____

DOES YOUR CHILD HAVE ANY **PETS**? NAMES _____ ANY HOBBIES? _____

WHAT IS THE REASON FOR THIS VISIT? _____

DID YOU EXPERIENCE ANY PROBLEM DURING PREGNANCY OR BIRTH OF YOUR CHILD?

HAS YOUR CHILD DEVELOPED AS YOU EXPECTED? YES NO _____

DO YOU FEAR DENTISTRY? YES NO _____

DOES YOUR CHILD FEAR DENTISTRY? YES NO _____

ARE THERE ANY HEREDITARY DENTAL PROBLEMS IN YOUR FAMILY? (MISSING TEETH. EXTRA TEETH. ETC.?).

HAS YOUR CHILD OR ANY MEMBER OF YOUR FAMILY EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS DENTAL OR MEDICAL CARE? .

HAS THERE EVER BEEN ANY INJURY TO YOUR CHILD'S TEETH OR MOUTH BY A FALL. BLOW. BUMP OR OTHERWISE?.

NAME OF CHILD'S PREVIOUS DENTIST _____

DOES YOUR CHILD TAKE ANY FLUORIDE SUPPLEMENTS? DROPS, TABLETS, DOES HE/SHE DRINK THE WATER IN MT. PLEASANT? YES NO_

PLEASE CIRCLE: HAS YOUR CHILD ANY HISTORY OF

HEART TROUBLE RHEUMATIC FEVER ALLERGIES DIABETES ASTHMA KIDNEY OR LIVER PROBLEM

EPILEPSY LUNG DISORDER GLANDULAR PROBLEM BLOOD OR CIRCULATORY PROBLEM

TRANSFUSIONS MENTAL OR EMOTIONAL DISORDER AIDS HEPATITIS

ANY RECENT SURGERY OTHER _____

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? YES NO NAME OF PHYSICIAN _____

IS YOUR CHILD **ALLERGIC** TO ANY MEDICINE OR FOODS?

HAS YOUR CHILD ANY HISTORY OF BEING UNDER OXYGEN OR GENERAL ANESTHESIA?

HAS YOUR CHILD EVER BEEN HOSPITALIZED?

IS YOUR CHILD UNDER MEDICAL CARE AT PRESENT? _____

IS YOUR CHILD TAKING ANY MEDICATION? _____

DOES YOUR CHILD HAVE ANY HEARING, SIGHT, SPEECH, COORDINATION, OR SPECIAL SCHOOLING PROBLEMS' .

ARE THERE ANY HEALTH OR OTHER PROBLEMS THAT SHOULD BE BROUGHT TO OUR DOCTORS ATTENTION?

PERMIT FOR DENTAL SERVICES UPON A MINOR

You will be informed of all services before any treatment is rendered for your child. Questions are welcome. If you feel uncomfortable with any treatment in our office, let us know and treatment will be discontinued at an appropriate stopping point.

I, being the parent (or guardian), of _____ do hereby authorize and request the performance of dental services upon the person named above and to do whatever procedures that the judgment of the Doctors may dictate during treatment.

I also authorize and request the administration of such anesthetics and/or sedatives that the Doctors consider necessary

Date _____ Signed _____ Relationship _____