Dr. Duga Dr. Feeney & Associates
Pediatric Dentistry
preventive dental care for infants, children and teens

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The following information and history are necessary for adequate treatment and understanding of your child. Thank you for completing it in full.

Patient's Full Name______________________________ Nickname__________________ Age_____yr _____mo

Sex___________ Race___________ Date of Birth_____________ Social Security # ___________________

Patient's Address____ Home Phone_________________

Street City State Zip

E-mail Address ____

School ____

Father's Full Name____ Social Security # __________________

His Address____ Phone _____________________

Street City State Zip

Date of Birth_______________________________ Cell Phone _____________________________________

Where Employed ____ Phone______________________

Mother's Full Name____ Social Security # __________________

Her Address____ Phone _____________________

Street City State Zip

Date of Birth_______________________________ Cell Phone _____________________________________

Where Employed ____ Phone______________________

Phone numbers for confirmation of appointment ____

With whom does patient live ____

Other children in family - names and ages ____

Dental Insurance? Yes ___ No ___ Company______________________________ Policy # _____________

Company______________________________ Policy # _____________

Child's Physician___________________________________ Family Dentist ______________________________

Whom may we thank for referring you to our office ____

(Doctor) or (Parent) or (Patient)

Address, if known ____

Street City State Zip

OVER

Health History

Is your child taking vitamins or fluorides? ❑ Yes ❑ No ❑ Don't Know Brand or type: ________________________

Do you have fluoride in your water system? ❑ Yes ❑ No ❑ Don't Know Source of drinking water: ______________
(City, Well, etc.)

Is your child in good health? ❑ Yes ❑ No ❑ Don't Know

Does your child have regular medical examinations? ❑ Yes ❑ No ❑ Don't Know Date of last exam: ___________________

Is your child up to date with immunizations? ❑ Yes ❑ No ❑ Don't Know

Is this your child's first visit to the dentist? ❑ Yes ❑ No ❑ Don't Know

Is your child a thumb / finger sucker? ❑ Yes ❑ No ❑ Don't Know

Does your child use a pacifier? ❑ Yes ❑ No ❑ Don't Know

At what age was nursing, bottle feeding or sippy cup discontinued? ________________

How often are the child's teeth brushed each day?__________________ By whom? ______________________________________

Check any of the following that may pertain to your child:

❑ Rheumatic fever	❑ Liver problem	❑ Epilepsy	❑ Mental disorder	❑ Seizures
❑ Heart condition	❑ Kidney problem	❑ Hepatitis	❑ Emotional disorder	❑ Pneumonia
❑ Speech disorder	❑ Asthma	❑ Diabetes	❑ Sickle Cell Anemia	❑ Heart murmur
❑ Hearing disorder	❑ Endocrine disorder	❑ Leukemia	❑ Autism	❑ Injury to teeth or mouth
❑ Vision disorder	❑ Cancer, tumors, blood disorders	❑ Bacterial or viral infections	❑ Night grinding or TMJ problems	❑ Blood Transfusion: (including at birth) Approximate Date:_____________
❑ Nervous disorder		❑ Recurrent headaches		
❑ Bleeding disorder	❑ Lung problem	❑ Retardation	❑ Congenital birth defects	
❑ Cerebral palsy	❑ Brain injury	❑ Behavioral/learning problem	❑ HIV +	

If yes to any, please explain: ____

Is your child presently taking any medication? ____
(Name of Medication and Dose)

Is your child allergic to anything? ____
(Please List)

Has your child experienced any unfavorable reaction to medicine? ❑ Yes ❑ No
(such as penicillin, over the counter pain medications, xylocaine) Please list: ______________________________

Is your child presently undergoing medical treatment? ❑ Yes ❑ No
If yes, please describe: ____

Has your child ever been hospitalized since birth? ❑ Yes ❑ No
If yes, please list: Date________________________ Reason ____________________________________

Has your child ever had an unfavorable experience in a dental office? ❑ Yes ❑ No

Date of your child's last dental care:_______________________ Were X-Rays taken? ❑ Yes ❑ No ❑ Don't Know

Does your child have a toothache? ❑ Yes ❑ No

Purpose of this appointment: ____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment: ____

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Your child is a minor, therefore, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. Restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health or his/her medications change, I will inform the doctor at the next appointment without fail. I realize that the parent bringing the patient to the office is responsible for payment of the account and I will be responsible for the cost of this dental care. In the event of default, I agree to pay a reasonable collection and/or attorney fee. Accounts may be subject to a 1.5% monthly service charge on balances 60 days or more past due. Accounts may be subject to a $50 charge for missed or broken appointments.

Date:________________________ ____
Signature of person completing form and responsible for payment of account

_________ Dental Assistant reviewing history _________ Doctor