Patient Name_____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Is your child being treated by a physician at this time?.....____Y ____N

Reason _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ___ Y ___N

Name, Dose, Frequency, & date started: _____

Has your child ever had a reaction to or problem with anesthetic? Describe: _____Y____N

Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? ____ Y ____N

Describe: _____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?.....____ Y ____ N

: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? ..... ____Y ____N

List: _____

Has there recently been any significant changes/disruptions to your child's family, home, or school routines? ___Y____N

Describe: _____

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office?..... ____Y ____N

Has your child's diet changed significantly since his/her last dental visit? ..... ____Y ____N

Describe: _____

Has your child been treated by another dentist/dental professional since last visiting our office?..... ____Y ____N

Reason: _____

Is there any other change in the child's medical, dental, or family history that the dentist should be told? ____Y____N

Describe: _____

Has your child been diagnosed with /exposed to any of the following in the past 48 hours?

[ ] Lice [ ] Pink eye [ ] Strep Throat [ ] Vomiting/Stomach bug

[ ] Cold sores/fever blisters [ ] Hand, foot, and mouth [ ] No to all of the above

Would you recommend our office? _____

Tell us how our office is performing? _____

How can we improve your visit in our office? _____

_____ _____ _____ _____

Signature of Parent/Guardian Relationship to child Date Signature of Staff Member Reviewing History

KIDZANIA

Pediatric Dentistry and Orthodontics

IN ORDER TO PROVIDE THE MOST EFFECTIVE AND EFFICENT CARE FOR YOUR CHILD, WE KINDLY REQUEST THAT PARENTS ALLOW CHILDREN AGED 3 AND OVER TO ATTEND THEIR DENTAL EXPERIENCE UNACCOMPANIED UNTIL THE DOCTOR STARTS THE EXAM. OUR TEAM IS HIGLY EXPERIENCED IN HELPING CHILDREN OVERCOME ANXIETY, INCLUDING SEPARATION ANXIETY, WHICH IS NOT UNCOMMON IN THIS AGE GROUP FOR CHILDREN. IF YOUR CHILD EXHIBITS NEGATIVE BEHAVIOR, PLEASE TRY NOT TO BE CONCERNED, AS THIS IS NORMAL AND WILL SOON DIMINISH. STUDIES AND EXPERIENCE HAVE SHOWN THAT MOST CHILDREN OVER THE AGE OF 3 REACT MORE POSITIVELY WHEN PERMITTED TO EXPERIENCE THE DENTAL VISIT ON THEIR OWN AND IN AN ENVIROMENT DESIGNED FOR CHILDREN. ADDITIONALLY, FOR THE PRIVACY AND SAFETY OF ALL PATIENTS, **ONLY ONE PARENT** IS ALLOWED TO ACCOMPANY THEIR CHILDREN IN THE BACK **DURING THE EXAM.**

THANK YOU FOR YOUR COOPERATION!

_____ DATE_____

(Parent or Guardian Signature)