



NEW PATIENT QUESTIONNAIRE & CONSENT

I. GENERAL INFORMATION

Residence Address Street _____	Home Phone _____
City _____ State _____	Zip Code _____
Father's Full Name _____	Social Sec # _____ - _____ - _____
Father's Date of Birth _____	Cell Phone # _____
Employed By _____	Work Phone _____
Mother's Full Name _____	Social Sec # _____ - _____ - _____
Mother's Date of Birth _____	Cell Phone # _____
Employed By _____	Work Phone _____

II. CHILD'S HISTORY

Child's Full Name _____	Social Sec # _____ - _____ - _____
Name Child Goes By _____ Age _____	Date of Birth _____
Place of Birth _____ Attends what school? _____	
Names & Ages of Brothers and Sisters _____	

III. MEDICAL HISTORY (Circle all appropriate conditions)

1. Has your child ever experienced any of the following:

a. Seizures loss of consciousness, fainting, Cerebral Palsy, trauma to the head, or developmental delay?	Yes	No
b. Heart Disease, Rheumatic Fever, Prolonged Bleeding or any Blood Dyscrasias or Disease, or Heart Murmur?	Yes	No
c. Shortness of Breath, difficulty in breathing, Pneumonia or any chronic infection of the respiratory tract (Bronchitis or Asthma)?	Yes	No
d. Liver Disease, Jaundice or any Malabsorption Syndrome?	Yes	No
e. Kidney or Bladder Disease?	Yes	No
f. Diabetes or Glandular problems?	Yes	No
g. Allergies or any unfavorable reaction(s) to any medicines such as: Penicillin, Aspirin, local anesthetic, & etc. Please list: _____	Yes	No
h. Latex Allergy?	Yes	No
i. Hepatitis?	Yes	No
j. HIV (AIDS)?	Yes	No

2. Has this patient had a blood transfusion? ___ Yes ___ No If so, when? _____
3. Has this patient seen a physician (Medical Doctor) in the last six months? ___ Yes ___ No
If so, why? _____
4. Is your child taking any medication(s) at this time? ___ Yes ___ No If so, what? _____
5. Has your child ever had a serious illness or operation? ___ Yes ___ No If so, what? _____

6. Has your child ever been hospitalized? ___ Yes ___ No For what? _____
7. Has your child had a physical exam within the last year? ___ Yes ___ No
8. Are there any medical problems or other medical information you feel we need to know? ___ Yes ___ No If so, what? _____
9. Name of Child's Physician or Pediatrician _____
10. Is your child: ___ Advanced ___ Progressing Normally ___ A Slow Learner ___ Hyperactive

Patient's Last & First Name: _____, _____

Date of Birth: _____

IV. DENTAL HISTORY

1. Who is your family dentist?		
2. Is this your child's first visit to the dentist?	Yes	No
3. Has your child had a toothache recently?	Yes	No
4. Has your child ever fallen and chipped or damaged any of his/her teeth?	Yes	No
5. Is there a history of oral habits (thumb-sucking, lib or nail biting)?	Yes	No
6. Do you rate your child's oral hygiene habits as being poor?	Yes	No

V. PAYMENT PLAN: (Please Check)

Cash _____ Check _____ Charge Card _____ Insurance _____ Medicaid _____ Other _____

VI. CONSENT

Your child is a minor, therefore it is necessary that a signed permission be obtained from a parent or guardian before any necessary dental service can be stated. I grant J. Barry Burgess, DMD or Richard A Simpson, DMD permission to provide my child's dental exam and treatment and I will be responsible for the cost of this dental care.

Signed by _____
Parent or Guardian (Please circle)

Date _____
Driver's License#/State _____

PAST DENTAL HISTORY

Child's Name _____ Age _____

Yes ___ No ___ Any current Toothaches or Pain?
Yes ___ No ___ Any history of loss of sleep due to tooth or gum discomfort?
Yes ___ No ___ Any history of pain with eating?
Yes ___ No ___ Taking any pain medication?

First Dental Visit: Age _____ Dentist _____ Type of Treatment _____

Last Dental Exam: Age _____ Dentist _____ Type of Treatment _____

Last X-Rays: _____ Last Topical Fluoride Treatment _____

Oral Hygiene: Who brushes child's teeth? _____ When? _____
Toothpaste brand: _____ Do you floss your child's teeth? ___Yes ___No
If so, how often? ___Daily ___Weekly ___Other

Fluoride History: Home water source— City ___ Well ___ Other _____
Does your child take Fluoride supplements? Yes ___ No ___
If so, what? _____
Does your child use Fluoride rinses or gels? Yes ___ No ___
If so, what? _____

Has your child ever had any difficulty, problems, or bad experiences with past dental care?
Please explain: _____

