Antigua

Dr. Rebecca A. Faunce D.M.D.

Please fill out completely prior to your scheduled appointment.

Child's name_____ Nickname_____
Age_____ Birth date_____ School_____ Grade_____
Favorite: Hobby_____ Sport_____ Toy_____ Person_____
Father's name_____ Birth date_____ SS#_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell_____
Employed by_____ Email_____
Mother's name_____ Birth date_____ SS#_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell_____
Employed by_____ Email_____
Whom may we thank for referring you _____

Contact In case of emergency:
Name:_____ **Relationship:**_____ **PhoneNumber:**_____

Dental Insurance

Primary subscriber's name_____ DOB_____
SS#_____ Insurance company_____
Group#_____ ID#_____ Phone_____
Secondary Subscriber's name_____ DOB_____
SS#_____ Insurance company_____
Group#_____ ID#_____ Phone_____

Child's Dental History

Dentist name_____ Phone_____
Last dental visit_____ For what service_____

YES NO

☐ ☐ Complaints of dental problems. If yes explain_____
☐ ☐ Any unhappy experiences. If yes explain_____
☐ ☐ Any injuries to: Mouth-Teeth-Head. If yes explain_____
☐ ☐ Any mouth habits: Thumb sucking-Nail biting-Mouth breathing-Nursing bottle habits-Pacifier-ect. If yes explain_____
☐ ☐ Any unusual speech habits. If yes explain_____
☐ ☐ Any lost teeth. If yes explain_____
☐ ☐ Have missing teeth been replaced. If yes explain_____
☐ ☐ Does your child brush teeth daily_____
☐ ☐ Do you assist child with brushing. If yes how often_____
☐ ☐ Is dental floss used. If yes how often_____
☐ ☐ Are disclosing tablets used_____
☐ ☐ Is Fluoride taken in any form_____
☐ ☐ Do you desire assistance in finding dental services for your child_____
☐ ☐ Orthodontic appliances worn now or ever been worn _____
☐ ☐ Any family member that is in or has had orthodontic treatment with our office. If yes which office and name of family member/s _____
_____
Child's attitude to dentistry_____

Child's Health History

Physician's name_____ Phone_____

Date of last physical examination_____ Results_____

YES NO

☐ ☐ Is child under care of a physician now_____

☐ ☐ Is child receiving any medication or drugs. If yes explain _____

_____

☐ ☐ Is there any excessive bleeding when cut_____

☐ ☐ Has child ever been hospitalized. If yes explain_____

☐ ☐ Has child ever had surgery. If yes explain _____

☐ ☐ Allergies to any drugs. If yes explain_____

☐ ☐ Allergies to any: Food-Pollen-Animals-Latex-Other _____

☐ ☐ Does child have good physical coordination _____

☐ ☐ Are there any emotional problems _____

Has child any history of or difficulty with any of the following:

_____Anemia	_____Asthma	_____Bladder
_____Cerebral Palsy	_____Chicken Pox	_____Chronic Sinus
_____Convulsions	_____Diabetes	_____Epilepsy
_____Fainting	_____Hearing	_____Heart
_____Kidney	_____Liver	_____Malignancies
_____Mastoid	_____Measles	_____Mononucleosis
_____Mumps	_____Rheumatic Fever	_____Thyroid
_____Tuberculosis	_____Venereal Disease	_____Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

_____

_____

_____

YES NO

☐ ☐ May we request release of your child's medical records_____

Summary:
(for doctor's use)

_____

_____

_____

_____

_____

Parent or Guardian Signature_____

Relation to child_____