DAVID B. BERNARD, D.D.S.

LEXINGTON MEDICAL CENTER

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FOR OUR YOUNG PATIENTS

Please fill in your answers as thoroughly as possible. In our office, we are interested in developing a complete dental health program for your child. In order to do this, we must know as much about the individual as we do about the teeth and tissue around them. No two people are the same; no two mouths are alike. Of course, all information will be held in strict confidence.

By working together, we can find a way to achieve our goal of good dental health for your child.

Thank you.

PATIENT INFORMATION: Date: _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Nickname _____

Home Street Address _____

City _____ Zip _____

Home Telephone Number _____

Date of Birth _____ Sex _____ (M / F)

School _____ Grade _____

Father's Name _____ Occupation _____

Social Security Number _____

Employed by _____ Business Phone _____

Business address _____

Mother's Name _____ Occupation _____

Social Security Number _____

Employed by _____ Business Phone _____

Business address _____

Names and ages of other children in family _____

_____

Whom may we thank for referring you? _____

Who is to be billed for services rendered? _____

Address _____ Telephone _____

Name of insurance company that may cover dental services _____

DENTAL HEALTH:

What prompted you to seek dental care for your child? _____

_____

How long has it been since your child's last thorough dental exam? _____

Are you happy with the appearance of your child's teeth? ..... YES NO

Are you interested in complete dental care for your child? ..... YES NO

Has your child ever been shown how to floss and brush his/her teeth? ..... YES NO

Have there been any injuries to the face, mouth, or teeth? ..... YES NO

Has your child ever sucked a thumb or fingers? ..... YES NO

Until what age? _____

Is your child a mouthbreather? ..... YES NO

Does your child have any speech problems? ..... YES NO

Have you been informed of any missing or extra permanent teeth? ..... YES NO

Is the water in your community flouridated? ..... YES NO

Do you use: community water _____ well-water _____

Would you like to be notified by our office for future preventive check-ups to maintain your child's dental health? ..... YES NO

How often does your child clean his or her teeth? _____ With what? _____

Are there any unusual sounds in ear during eating (clicking) or pain in the region of the ear? ..... YES NO

Has your child ever had an orthodontic examination or orthodontic treatment? ..... YES NO

Is your child nervous or frightened during dental visits? If yes, please circle

Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

Has your child had Novocaine (Xylocaine)? ..... YES NO

Has your child had Nitrous Oxide (laughing gas, sweet air)? ..... YES NO

It would be helpful if you would indicate below what things you are looking for most in choosing a family dentist.

_____

_____

Has your child had any unfavorable medical or dental experience? ..... YES NO

If so, please explain _____

MEDICAL HEALTH:

1. Is your child in good health? ..... YES NO

2. Date of last physical examination _____

3. Is your child now under the care of a physician? ..... YES NO

If so, what is the condition being treated? _____

4. Name of Family Physician or Pediatrician _____

Address: _____

5. Has your child had any serious illness or operation? ..... YES NO

If so, what was the illness or operation? _____

6. Does your child have or has your child had any of the following?

a. Rheumatic fever or rheumatic heart disease ..... YES NO

b. Heart murmurs ..... YES NO

c. Congenital heart lesions ..... YES NO

d. Cardiovascular Disease ..... YES NO

Keep Going - You're Doing Well!

e. Allergy ..... YES NO

f. Sinus trouble ..... YES NO

g. Asthma or hay fever ..... YES NO

h. Hives or skin rash ..... YES NO

i. Fainting spells or seizures ..... YES NO

j. Diabetes ..... YES NO

k. Hepatitis, jaundice, or liver disease ..... YES NO

l. Arthritis ..... YES NO

m. Stomach ulcers ..... YES NO

n. Kidney trouble ..... YES NO

o. Tuberculosis ..... YES NO

p. Low blood pressure ..... YES NO

q. Thyroid problem ..... YES NO

r. Anemia ..... YES NO

s. Bone disorders ..... YES NO

t. Mononucleosis ..... YES NO

u. Metabolic or growth problems ..... YES NO

v. Hemophilia or bleeding problems ..... YES NO

w. Other _____

7. Has your child had abnormal bleeding associated with previous extractions, surgery, or trauma? ..... YES NO

8. Is your child taking any drug or medicine? ..... YES NO

If so, what? _____

9. Is your child allergic to any of the following?

a. Aspirin ..... YES NO

b. Penicillin or other antibiotics ..... YES NO

c. Novocaine (Xylocaine) ..... YES NO

d. Codeine ..... YES NO

e. Foods ..... YES NO

f. Other _____

10. Have your child's tonsils and adenoids been removed? ..... YES NO

11. Does your child have any mental or physical disability? ..... YES NO

If so, please explain _____

12. Does your child have any disease, condition, or problem not listed above that you think we should know about? ..... YES NO

If so, please explain _____

Thank you very much!

_____ _____

Date Signature of Parent (Guardian)

_____ _____

Date Signature of Dentist