DR. MICHELLE LAMERS –CHILDREN'S FORM

Child's Name: _____ Date of Birth: _____
School: _____ Grade: _____
Residence: _____ City: _____ State: _____ Zip: _____
Child's favorite toy: _____ Pet: _____ Friend: _____ Hobby: _____
Child's attitude towards dental visit: _____

Father's Name: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Employed By: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Father's Date of Birth: _____

Mother's Name: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Employed By: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Mother's Date of Birth: _____

Name and ages of other siblings: _____

Emergency contacts

Nearest Relative: _____ Phone: _____
Nearest Friend: _____ Phone: _____
Landlord (if renting): _____ Phone: _____
PERSON RESPONSIBLE FOR PAYMENT _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Company: _____	_____
Policy Holder: _____	_____
Social Security No: _____	_____

Whom should we thank for referring you to our practice? _____

THANK YOU FOR CHOOSING OUR OFFICE.

Child's First Name: _____ Last Name: _____ Date of Exam: _____

Child's Health History

General Health ____excellent ____good ____fair ____poor

Child's Physician: _____ Phone: _____
Address: _____
Date of last physical exam:

Check if you child had or now has any of the following condition(s):

____A.I.D.S/HIV	____Bleeding Disorder	____Cerebral Palsy
____Kidney disease	____Anemia	____Bone disorders
____Diabetes	____Asthma	____Endocrine
____Rheumatic fever	____Heart trouble	____Arthritis
____Hepatitis	____Epilepsy/convulsions	____Broken bones
____Liver disease	____Speech impedimen	____A.D.H.D.
____Tuberculosis	____Hearing problem	____Mononucleosis

Other:

Does child have any allergies? Yes No
If Yes, To What?

Does child have any emotional problems? Yes No

Is child taking any medications now? Yes No
If Yes, please describe:

Has your child ever used: Drugs Alcohol Tobacco Products

Is your child menstruating / pregnant: Yes No
How long:

I VERIFY THE ABOVE & GIVE MY CONSENT FOR TREATMENT

_____
PARENT OR GUARDIAN'S SIGNATURE

Child's Dental Information

1. How long since your child's last dental examination?
2. What concerns you most about your child's dental health?
3. Does your child ever have dental pain? If so, when?
4. Did your child ever have a negative dental experience?
   Please explain:
5. Has the child had any injuries to the face? _____
   (Please Check) ____mouth ____ teeth ____face
   When? _____ Where _____
   How?
6. Has the child ever sucked a thumb or fingers?
   Until what age?
7. Does the child snore or grind his/her teeth?
8. Is the child a mouth-breather?
   While awake? _____ While asleep? _____
9. Has the child had teeth removed?
10. Has the child had orthodontic treatment?
11. How often does your child brush? ___times/day. Floss? ___
12. Has child received any flouride ____pill/vitamins ____water