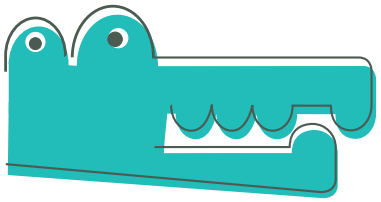
NEW ORLEANS CHILDRENS DENTAL CENTER



WELCOME NEW PATIENT

PATIENT INFORMATION:

PATIENT NAME: NICKNAME:

DATE OF BIRTH: SEX: HOME PHONE

ADDRESS: CITY: STATE: ZIP:

PARENT OR GUARDIAN NAME:

SCHOOL: GRADE:

SIBLINGS: (NAMES & AGES)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE:

PARENT'S INFORMATION:

PARENT'S MARITAL STATUS: ○ MARRIED ○ DIVORCED ○ SEPARATED ○ WIDOWED ○ REMARRIED ○ SINGLE

MOTHER'S NAME: BIRTHDATE:

ADDRESS: CITY: STATE: ZIP:

HOME NO: WORK NO: CELL NO:

EMPLOYER: OCCUPATION:

DRIVERS LICENSE NO: SOCIAL SECURITY NO:

EMAIL:

FATHER'S NAME: BIRTHDATE:

ADDRESS: CITY: STATE: ZIP:

HOME NO: WORK NO: CELL NO:

EMPLOYER: OCCUPATION:

DRIVERS LICENSE NO: SOCIAL SECURITY NO:

EMAIL:

DENTAL INSURANCE INFORMATION:

1.INSURED'S NAME: SOCIAL SECURITY NO: DOB:

GROUP NAME: GROUP POLICY NO:

INSURANCE COMPANY NAME: PHONE NO:

ADDRESS: CITY: STATE: ZIP:

2.INSURED'S NAME: SOCIAL SECURITY NO: DOB:

GROUP NAME: GROUP POLICY NO:

INSURANCE COMPANY NAME: PHONE NO:

ADDRESS: CITY: STATE: ZIP:

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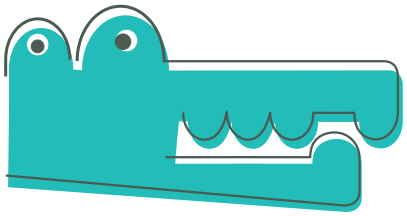

MEDICAL HISTORY QUESTIONAIRE

CHILD'S MEDICAL HISTORY:

PATIENT NAME: CHILD'S PHYSICIAN: DATE OF LAST VISIT:

ARE IMMUNIZATIONS CURRENT? ◯ YES ◯ NO

IS YOUR CHILD UNDER MEDICAL CARE AT PRESENT? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS? PLEASE CHECK OFF ALL THAT APPLY:

- ◯ ADD/ADHD
- ◯ ALLERGIES
- ◯ ANEMIA
- ◯ ANXIETY/DEPRESSION
- ◯ ASTHMA
- ◯ AUTISM/ASPERGER
- ◯ BLEEDING DISORDERS
- ◯ CANCERS
- ◯ CEREBRAL PALSY
- ◯ CLEFT LIP/PALATE
- ◯ HIGH BLOOD PRESSURE
- ◯ CHRONIC SINUS INFECTIONS
- ◯ CHRONIC EAR INFECTIONS
- ◯ CYSTIC FIBROSIS
- ◯ SEIZURES/EPILEPSY
- ◯ DEVELOPMENTAL DELAY
- ◯ DIABETES
- ◯ DOWN SYNDROME
- ◯ HIV/AIDS
- ◯ HEPATITIS
- ◯ MENTAL RETARDATION
- ◯ LEARNING DISABILITIES
- ◯ HEART DISEASE
- ◯ HEART MURMUR
- ◯ HEART DEFECTS
- ◯ HEMOPHILIA
- ◯ KIDNEY PROBLEMS
- ◯ LIVER PROBLEMS
- ◯ LUNG PROBLEMS
- ◯ PSYCHIATRIC TREATMENTS
- ◯ SPEECH/HEARING PROBLEMS
- ◯ BIRTH DEFECTS
- ◯ PREMATURE BIRTH
- ◯ RHEUMATIC FEVER
- ◯ SICKLE CELL DISEASE
- ◯ SICKLE CELL TRAIT
- ◯ TUBERCULOSIS
- ◯ NEUROLOGICAL PROBLEMS
- ◯ ORTHOPEDIC PROBLEMS
- ◯ EYE PROBLEMS
- ◯ ACID REFLUX
- ◯ EMOTIONAL DISTURBANCES

DOES YOUR CHILD HAVE ANY OTHER DISEASES, CONDITIONS, OR SYNDROMES NOT LISTED ABOVE? ◯ YES ◯ NO IF YES, PLEASE EXPLAIN:

IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? ◯ YES ◯ NO

IF YES, PLEASE LIST:

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? ◯ YES ◯ NO IF YES, PLEASE LIST:

HAS YOUR CHILD EVER BEEN SEDATED OR HAD GENERAL ANESTHESIA? ◯ YES ◯ NO IF YES, WHAT FOR?

HAS YOUR CHILD EVER HAD SURGERY OR BEEN HOSPITALIZED? ◯ YES ◯ NO IF YES, PLEASE EXPLAIN:

IS YOUR CHILD HAVING ANY DIFFICULTIES IN SCHOOL? ◯ YES ◯ NO IF YES, PLEASE EXPLAIN:

DO YOU CONSIDER YOUR CHILD TO BE:

◯ ADVANCED IN LEARNING ◯ PROGRESSING NORMALLY ◯ A SLOW LEARNER

IS THERE ANYTHING WE SHOULD KNOW ABOUT YOUR CHILD?

IS THERE ANYTHING ABOUT YOUR CHILD YOU WOULD LIKE TO DISCUSS IN PRIVATE? ◯YES ◯NO

CHILD'S DENTAL HISTORY:

PLEASE CHECK OFF REASON(S) FOR SEEKING DENTAL CARE:

○ FIRST EXAMINATION ○ ROUTINE CHECK-UP ○ TOOTHACHE OR SWELLING ○ CAVITIES
○ APPEARANCE OF TEETH ○ CROWDING ○ ACCIDENT/INJURY

OTHER:

HAS YOUR CHILD BEEN TO A DENTIST PREVIOUSLY? ○ YES ○ NO

WHEN: WHERE:

WERE X-RAYS TAKEN: ○ YES ○ NO ○ NOT SURE

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS:

○ THUMB/FINGER SUCKING ○ MOUTH BREATHING ○ PACIFIER ○ SNORING
○ BOTTLE/SIPPY CUP ○ LIP SUCKING/BITING ○ GRINDING/CLENCHING

DOES YOUR CHILD HAVE FLUORIDE IN ANY OF THE FOLLOWING FORMS:

○ TOOTHPASTE ○ DRINKING WATER ○ HOME FLUORIDE RINSES/GELS/VARNISH ○ FLUORIDE TABLETS/VITAMINS

WHAT TYPE OF WATER DOES YOUR CHILD DRINK:

IS YOUR CHILD STILL BREAST FED OR USING A BOTTLE/SIPPY CUP? ○ YES ○ NO
IF NO, WHAT AGE WAS IT STOPPED? FREQUENCY OF TOOTH BRUSHING?
FLOSSING? WHO DOES THE BRUSHING? ○ CHILD ○ PARENT/GUARDIAN

HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT? (CHECK ALL THAT APPLY)

○ OUTGOING ○ SHY ○ STUBBORN ○ ANXIOUS ○ FRIGHTENED ○ REGULAR KID
○ CURIOUS ○ MOODY ○ FRIENDLY ○ DEFIANT ○ HIGH STRUNG ○ COOPERATIVE

HAS YOUR CHILD EVER EXPERIENCED ANY PROBLEMS OR COMPLICATIONS FROM PREVIOUS DENTAL CARE? ○ YES ○ NO

IF YES, PLEASE EXPLAIN:

CONSENT:

THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZE DR. CAVALLINO AND DR. AXELRAD TO COMPLETE A DENTAL EVALUATION AND PERFORM THE NECESSARY DENTAL SERVICES FOR MY CHILD.

SIGNATURE OF PARENT/GUARDIAN DATE:

OFFICE USE ONLY:

SUMMARY:

SBE PROPHYLAXIS REQUIRED ○ YES ○ NO PRECAUTIONS:

INITIALS OF REVIEWING DENTIST: DATE: