Kenneth R. Whitcomb, DDS

CHILDREN'S BRACES AND DENTISTRY

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ABOUT YOUR CHILD

_____
CHILD'S FULL NAME

_____
NAME CHILD PREFERS TO BE CALLED

_____☐ M ☐ F_____
AGE DATE OF BIRTH

_____
WEIGHT HEIGHT

REASON FOR VISIT _____

_____

REFERRED BY _____
FULL NAME

PHONE # _____

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT ☐ YES ☐ NO

_____
PREVIOUS DENTIST CITY

DATE OF LAST VISIT _____

ANY INJURIES TO YOUR CHILD'S TEETH, JAWS, HEAD OR NECK? ☐ YES ☐ NO

WHEN? _____

HISTORY OF: WHEN?
- ☐ Nursing bottle habit _____
- ☐ Thumb/finger/lip habits _____
- ☐ Pacifier _____
- ☐ Recent dental pain _____
- ☐ Previous dental treatment _____

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE?
☐ YES ☐ NO (Please explain) _____

_____

_____

PLEASE RELATE ANY INFORMATION THAT WILL HELP US UNDERSTAND YOUR CHILD

_____

_____

_____

MEDICAL HISTORY

_____
CHILD'S PHYSICIAN/PEDIATRICIAN PHONE #

- Does your child have a history of health problems or any illnesses? ☐ Yes ☐ No
  Please explain: _____
  _____
- Is your child presently under the care of his/her physician for any medical reason? ☐ Yes ☐ No
  Please explain: _____
  _____
- Is your child presently under the care of a specialist for any medical reason? ☐ Yes ☐ No
  Please explain: _____
  _____

_____
SPECIALIST'S NAME PHONE #

- Are antibiotics necessary for dental treatment because of heart murmur, heart defect, prosthesis, shunt or other medical reason? ☐ Yes ☐ No
- Is your child presently taking any medications? ☐ Yes ☐ No
  What? _____
- Has your child had a history of taking mediations frequently? Which ones? _____ ☐ Yes ☐ No
- Has your child ever been hospitalized or had surgery Including same-day surgery? ☐ Yes ☐ No
  For what _____
- Is your child allergic to any drugs/medicines? ☐ Yes ☐ No
- Has your child ever had any adverse reactions to any medications, drugs, or latex ? ☐ Yes ☐ No
  If yes, what? _____
- Has your child or any member of his/her family ever had a problem with a general anesthetic? ☐ Yes ☐ No
  Please explain: _____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? CHECK YES OR NO:

Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Fever Blisters
☐	☐	Anemia	☐	☐	Growth /Development Problems
☐	☐	Arthritis	☐	☐	Heart Surgery
☐	☐	Asthma	☐	☐	Headaches
☐	☐	Autism	☐	☐	Hearing/Speech Impediment
☐	☐	Bladder conditions	☐	☐	Heart Murmur/Defect
☐	☐	Blood Disease	☐	☐	Hemophilia
☐	☐	Birth Defects	☐	☐	Hepatitis/Liver Disease
☐	☐	Bone or Joint Problems	☐	☐	Hyperactivity/ADD
☐	☐	Brain Injury	☐	☐	Kidney Disease
☐	☐	Bruising Easily	☐	☐	Leukemia
☐	☐	Cancer or Malignancies	☐	☐	Mental Disability
☐	☐	Cerebral Palsy	☐	☐	Mouth Sores
☐	☐	Chemotherapy/Radiation	☐	☐	Nutritional Deficiency
☐	☐	Child Abuse	☐	☐	Orthopedic Problems
☐	☐	Chronic Adenoid/ Tonsil Infection	☐	☐	Pain in Jaw Joints
☐	☐	Chronic Ear Infections	☐	☐	Premature Birth
☐	☐	Cleft Lip/Palate	☐	☐	Psychiatric Care
☐	☐	Congenital Heart Defects	☐	☐	Rheumatic Fever
☐	☐	Convulsions/Seizures	☐	☐	Scoliosis
☐	☐	Developmental Delay	☐	☐	Sickle Cell Anemia
☐	☐	Diabetes	☐	☐	Snoring/MouthBreathing
☐	☐	Drug Addictions	☐	☐	Syndrome _____
☐	☐	Emotional Disturbance	☐	☐	Tuberculosis
☐	☐	Epilepsy	☐	☐	Other _____
☐	☐	Eye Problems	☐	☐	Do you wish to talk to the doctor privately about a special concern?
☐	☐	Excessive Bleeding			
☐	☐	Excessive Gagging			
☐	☐	Fainting or Dizziness			

PREVENTIVE
DENTAL HISTORY

How often does your child brush? _____

Is tooth-brushing supervised? ☐ Yes ☐ No

Is dental floss used? ☐ Yes ☐ No

Does your child receive:

- ☐ Fluoride in vitamins
- ☐ Fluoride tablets or drops
- ☐ Fluoridated tap water
- ☐ Bottled water
- ☐ Well water

INSURANCE INFORMATION

INSURED'S NAME DOB

_____
ADDRESS/PHONE (IF DIFFERENT)

_____ _____
PRIMARY INSURANCE ADDRESS

_____ _____
GROUP # POLICY #

DUAL COVERAGE? ☐ YES ☐ NO

_____ _____
SECONDARY INSURANCE ADDRESS

_____ _____
GROUP # POLICY #

RESPONSIBLE PARTY
FATHER/MOTHER

_____
FATHER'S FULL NAME (OR LEGAL GUARDIAN)

_____
ADDRESS

_____
CITY STATE ZIP CODE

_____ _____ _____
SOCIAL SECURITY # BIRTH DATE E-mail

_____ _____ _____
HOME PHONE # BUSINESS PHONE # CELL #

_____ _____ _____
OCCUPATION EMPLOYER E-MAIL

_____
MOTHER'S FULL NAME (OR LEGAL GUARDIAN)

_____
ADDRESS (IF DIFFERENT)

_____
CITY STATE ZIP CODE

_____ _____
SOCIAL SECURITY # BIRTH DATE

_____ _____ _____
HOME PHONE # BUSINESS PHONE # CELL #

_____ _____
OCCUPATION EMPLOYER

PARENTS ARE:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Legal Guardian

THE PERMISSION OF THE PARENT OR LEGAL GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR.

I give doctors Surillo/Whitcomb permission to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic and/or unusual reactions to drugs, food, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me.

- I hereby certify the foregoing information is true and correct. _____ _____
  SIGNATURE DATE

  _____
  RELATIONSHIP

- I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

  _____
  SIGNED (PATIENT OR PARENT OF MINOR)

- I hereby authorize payment to the above named dentists of the group insurance benefits otherwise payable to me.

  _____
  SIGNED (INSURED PERSON)