

Don R. Gifford, D.D.S.

In-Office # \_\_\_\_\_

The answers to the following questions are of great value in  
aiding us to a better understanding of your child.

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Nickname, if any: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Physician or Pediatrician: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Parent's or Guardians' Name: \_\_\_\_\_

Purpose for this appointment: \_\_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

**MEDICAL INFORMATION: PLEASE RESPOND TO EVERY QUESTION**

A. Has your child ever been hospitalized or been in a hospital? \_\_\_\_\_  
Emergency Room? \_\_\_\_\_ If yes, why? \_\_\_\_\_

B. Is your child now under the care of a physician? \_\_\_\_\_  
If so, why? \_\_\_\_\_

C. List the medications your child is now taking: \_\_\_\_\_

D. List your child's allergies: \_\_\_\_\_

E. Has your child ever had a reaction to penicillin or any other drugs? \_\_\_\_\_  
If so, what drugs? \_\_\_\_\_

F. Does your child take any type of fluoride at present? \_\_\_\_\_

G. Does your child now have or has he/she ever had any of the following? (check yes or no)

	yes	no		yes	no
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease or Trait .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Brain Damage .....	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Birth defects .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

1. Has your child had history of  thumbsucking,  fingersucking,  lip biting, or  nail biting? (check)

2. Has your child had any unfavorable experiences in a  dental or  medical office? (check)

3. Is your child high strung or generally nervous? \_\_\_\_\_

4. Has your child had a toothache recently? \_\_\_\_\_

Because your child is a minor, a signed permission is required from a parent or guardian before any dental service can begin. Authorization is hereby granted, furthermore, I will be responsible for any bill incurred on this child for dental treatment and if collection procedures are initiated, I agree to pay all costs and expenses, including attorneys fees and interest at an 18% annual rate, incurred during the collection process. I understand that where appropriate, credit bureau reports may be obtained.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_