Manitou Dental

Patient's Name _____ Nickname _____
Date of Birth_____ Age _____ ☐ Female ☐ Male
Mother's Name _____ Occupation _____
Father's Name _____ Occupation _____
Address _____
Home Phone _____ Cell Phone _____

Medical History

Has the child had any history of, difficulty with, or diagnosis of any of the following:

YES NO	YES NO	YES NO	YES NO
☐ ☐ ADD/ADHD	☐ ☐ Cerebral Palsy	☐ ☐ HIV +/AIDS	☐ ☐ Rheumatic fever
☐ ☐ Anemia	☐ ☐ Chicken Pox	☐ ☐ Immunizations	☐ ☐ Ringworm
☐ ☐ Arthritis	☐ ☐ Chronic Sinusitis	☐ ☐ Kidney	☐ ☐ Seizures
☐ ☐ Asthma	☐ ☐ Developmental Delay	☐ ☐ Latex allergy	☐ ☐ Sex. Trans. Disease
☐ ☐ Autism/PDD	☐ ☐ Diabetes	☐ ☐ Liver	☐ ☐ Sickle cell
☐ ☐ Behavioral Problems	☐ ☐ Epilepsy	☐ ☐ Measles/Mumps	☐ ☐ Thyroid
☐ ☐ Bladder	☐ ☐ Fainting	☐ ☐ Mononucleosis	☐ ☐ Tobacco/Drug Use
☐ ☐ Bleeding disorders	☐ ☐ Growth Problems	☐ ☐ Pregnancy (teens)	☐ ☐ Tuberculosis
☐ ☐ Blood Transfusions	☐ ☐ Hearing	☐ ☐ Previous Surgeries	☐ ☐ Warts
☐ ☐ Bones/Artificial Joints	☐ ☐ Heart/ Heart Murmur	☐ ☐ Previous Hospitalizations	☐ ☐ Other _____
☐ ☐ Cancer	☐ ☐ Hepatitis		

Medications _____
Allergies (Medications, foods, etc) _____
Name of Physician _____ Phone _____ Last Visit _____

Dental History

Previous Dentist _____ Date of Last Visit _____
Date of Last Dental X-Rays_____ Date of Last Dental Cleaning_____
Has child complained about dental problems? Yes ☐ No ☐
Does child brush daily? Yes ☐ No ☐
Does child floss daily? Yes ☐ No ☐
Does child take any Fluoride supplements? Yes ☐ No ☐
Any history of dental or facial trauma? Yes ☐ No ☐
Any unhappy dental experiences? Yes ☐ No ☐
Does your child get cold sores, apthous ulcers, ulcers, or canker sores? Yes ☐ No ☐
Any harmful habits (thumb-sucking, nail biting, pacifier, sleeping with bottle, mouth breathing, grinding) Yes ☐ No ☐

Declaration

I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the staff at ManitouDental to perform such treatments, services, medications, local anesthesia, analgesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease. If any conditions are discovered in the course of treatment which, in the opinion of the doctors authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from treatment, I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education. I certify that I have read the above Consent and questions were answered to my satisfaction.
Parent's/Guardian's Signature _____ Date _____
Dentist's Signature _____ Date _____