

Doc Bresler's Cavity Busters

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 |
| <input type="checkbox"/> <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> <input type="checkbox"/> HIV +/-AIDS | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> <input type="checkbox"/> Immunizations | <input type="checkbox"/> <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> <input type="checkbox"/> Kidney | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> <input type="checkbox"/> Latex allergy | <input type="checkbox"/> <input type="checkbox"/> Sex. Trans. Disease |
| <input type="checkbox"/> <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Liver | <input type="checkbox"/> <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> <input type="checkbox"/> Bladder | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> <input type="checkbox"/> Tobacco/Drug Use |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> <input type="checkbox"/> Growth Problems | <input type="checkbox"/> <input type="checkbox"/> Pregnancy (teens) | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> <input type="checkbox"/> Hearing | <input type="checkbox"/> <input type="checkbox"/> Previous Surgeries | <input type="checkbox"/> <input type="checkbox"/> Warts |
| <input type="checkbox"/> <input type="checkbox"/> Bones/Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Heart/ Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Previous Hospitalizations | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> 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

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 Doc Bresler's Cavity Busters 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 _____