

# 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 \_\_\_\_\_  
Email Address \_\_\_\_\_ Referred by Whom \_\_\_\_\_

## 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 \_\_\_\_\_