Dr. Egg Pediatric Dentistry

PATIENT NAME: _____ DATE:_____

DENTAL HISTORY

Purpose of today's visit: _____

Has your child ever been to the dentist: □ YES □ NO If YES, where? _____

Date of last xrays? _____

Has your child ever experienced any unfavorable reaction from a previous dental visit? □ YES □ NO

If YES, please explain: _____

Was your child □ BREAST FED Age when stopped: _____ □ BOTTLE FED Age when stopped: _____

Does your child suck a finger, thumb or pacifier? □ YES □ NO

Does your child have pain with chewing, yawning, or wide opening? □ YES □ NO

Does your child's jaw make noise and is pain associated with the sounds? □ YES □ NO

Please check if your child is having problems with any of the following:

□ Cavities	□ Toothache	□ Sensitive Teeth
□ Trauma	□ Gum Infections	□ Color of Teeth
□ Orthodontics	□ Jaw Sounds	□ OTHER DENTAL CONCERNS

Comments:_____

_____

FLUORIDE HISTORY

Type of water source? □ Private Well □ City Water System If your home water fluoridated? □ YES □ NO

Does your child use a fluoride toothpaste? □ YES □ NO

Do you give your child any other form of fluoride? □ YES □ NO If YES, what? _____

Does your child participate in a school fluoride rinse program? □ YES □ NO

CONSENT FOR DENTAL TREATMENT

I REQUEST AND AUTHORIZE Dr. Eggleston to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Eggleston to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child's teeth for diagnostic or educational pruposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Eggleston will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____