



TODAY'S DATE:

CHILD'S LAST NAME:	FIRST NAME:	INITIAL:
NICKNAME:	GENDER: M F	
BIRTHDAY:	SOCIAL SECURITY:	
HOME ADDRESS:	CITY:	STATE:
ZIP CODE:		
SCHOOL:	GRADE:	

PARENT'S INFO:

LAST NAME:	FIRST NAME:	INITIAL:
BIRTHDATE:	SOCIAL SECURITY:	
HOME ADDRESS:		
CITY:	STATE:	ZIP:
BEST PHONE NUMBER:	EMAIL ADDRESS:	

WHO IS ACCOMPANYING THE CHILD TODAY? SAME AS ABOVE? YES NO
(IF YES, SKIP TO NEXT PAGE)

LAST NAME:	FIRST NAME:	INITIAL:
RELATION:	LEGAL GUARDIAN OF THIS CHILD?	YES NO



maple street
dental group

WHO MAY WE THANK FOR REFERRING YOU?

ANY RELATIVES SEEN BY US:

REASON FOR TODAY'S VISIT:

IS THE CHILD'S WATER FLUORIDATED? YES NO

DOES THE CHILD BRUSH HIS/HER TEETH DAILY? YES NO

FLOSS HIS/HER TEETH DAILY? YES NO

PREVIOUS DENTIST:

DATE OF LAST VISIT:

WHY DID YOU LEAVE YOUR PREVIOUS DENTIST?

CHILD'S PHYSICIAN:

PHONE NUMBER:

DATE OF LAST VISIT:

IMMUNIZATIONS CURRENT? YES NO

CHILD'S CURRENT PHYSICAL HEALTH: GOOD FAIR POOR

DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

	BREAST FED		MOUTH BREATHER		THUMB/FINGER SUCKING
	CHEWING ON OBJECTS		NAIL BITING		TONGUE/CHEEK BITING
	CLENCHING/GRINDING		NURSING BOTTLE HABITS		TONGUE THRUST
	SPEECH PROBLEMS		USED PACIFIER		LIP SUCKING/BITING



HAS THE CHILD HAD/EXPERIENCED ANY OF THE FOLLOWING?

ABNORMAL BLEEDING	DIABETES	LOW BLOOD PRESSURE
AIDS/HIV	EPILEPSY	LUPUS
ALLERGIES	MEASLES	HANDICAPS/DISABILITIES
ANEMIA	HEARING IMPAIRED	MITRAL VALVE PROLAPSE
ANY HOSPITAL STAYS	HEART MURMUR	MONONUCLEOSIS
ASTHMA	HEMOPHILIA	RHEUMATIC FEVER
BLOOD TRANSFUSION	HEPATITIS	SCARLET FEVER
CANCER	HYPERTENSION	SICKLE CELL ANEMIA
CHICKEN POX	HIVES	SKIN RASH
CONGENITAL HEART DEFECT	KIDNEY PROBLEMS	TONSILITIS
CONVULSIONS	LIVER PROBLEMS	TUBERCULOSIS (TB)

PLEASE DISCUSS ANY OTHER SERIOUS MEDICAL PROBLEMS:

PLEASE LIST ALL DRUGS THAT THE CHILD IS CURRENTLY TAKING;

IS THE CHILD ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN	ERYTHROMYCIN	METALS
CODEINE	JEWELRY	PENICILLIN
DENTAL ANESTHETICS	LATEX	TETRACYCLINE

ANY OTHER ALLERGIES? PLEASE LIST:



I consent to my child having the following done: X-rays, Exam, Prophylaxis (cleaning).

INITIAL HERE:

I understand that holding my mouth open during treatment may temporarily leave my child's jaw feeling stiff and sore and may make it difficult to open wide for several days. I must notify your office if this or other concerns arise. I understand that if the recommended treatment is not performed, tooth or gum damage may progress causing me to lose one or more teeth. My child may also experience symptoms that may be damaging to overall health and which may increase in severity, and the cosmetic appearance of the teeth may deteriorate. I understand that every reasonable effort will be made to ensure the success of treatment. I understand that each person and situation is unique, and no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve my child's condition(s).

INITIAL HERE:

I understand that antibiotics, anesthetics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore it is critical that I tell my dentist of all medications my child is currently taking, which I have done.

INITIAL HERE:

I understand that loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections for local anesthesia is possible with any procedure. Rarely, temporary or permanent nerve injury and loss of feeling may result from an injection.

INITIAL HERE:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

INITIAL HERE:

OFFICE USE ONLY

Confirmation of review of medical / dental information above with the patient named herein, and attestation of discussion of the risks, benefits, consequences, and alternatives of proposed treatment. Patient will be given the opportunity to ask questions, and I will ensure the patient understands what has been explained.



DR. MATTHEW WEGRZYN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, _____, HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE:

DATE:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

<input type="checkbox"/>	Individual refused to sign
<input type="checkbox"/>	Communications barriers prohibited obtaining the acknowledgement.
<input type="checkbox"/>	An emergency situation prevented us from obtaining acknowledgement.
<input type="checkbox"/>	Other (to be documented in chart notes)