

SCOTT H. LEAF, D.D.S.
DENTISTRY FOR CHILDREN

I. GENERAL INFORMATION

- A. Child's Name _____ Nickname _____
 B. Sex _____ Age _____ Date of Birth _____
 C. Father's / Guardian's Name _____
 D. Mother's / Guardian's Name _____
 E. Home Address _____
 F. City & State _____ Zip _____ Home Phone _____
 G. Cell Phone _____ Email _____
 H. Marital Status: Married Divorced Single Other
 I. Person responsible for account _____
 J. Parental Guardian Employment _____
 Address _____ Bus. Phone _____
 K. Parental Guardian Employment _____
 Address _____ Bus. Phone _____
 L. Prior Dentist _____ Phone _____
 M. Who referred you to us? _____
 N. Reason for bringing child to the dentist _____

II. CHILD'S MEDICAL HISTORY

- | | Yes | No |
|--|-----|-----|
| A. Child's Physician _____ | () | () |
| B. Is your child being treated by the physician presently? | () | () |
| C. Has your child ever been a patient in the hospital? | () | () |
| D. Does your child have any allergies to any drug or food?
If so, what _____ | () | () |
| E. Is your child presently taking any medicines?
If so, what medicines _____ | () | () |
| F. Does your child have any difficulty in school? | () | () |
| G. Has your child any history of rheumatic fever, heart trouble, heart murmur, hepatitis, asthma, diabetes, kidney or liver involvement, mental retardation, blood disease or excessive bleeding, or brain damage?
(If yes, please underline condition) | | |
| H. Have you ever been told by your doctor that your child needs antibiotic prophylaxis before dental procedures? | () | () |

III. CHILD'S DENTAL HISTORY

- | | | |
|---|-----|-----|
| A. Has your child ever been seen by a dentist | () | () |
| B. Has your child experienced any unfavorable reaction from any previous dental or medical care? | () | () |
| C. Is either parent subject to much tooth decay? | () | () |
| D. Has your child ever had a local anesthetic (novocaine)? | () | () |
| E. Does your child suck his fingers or thumb? | () | () |
| F. Does your child have (or had) a toothache, sensitive teeth, teeth bumped, discolored teeth, bleeding gums?
(If yes, please underline) | | |
| G. Is your community water supply fluoridated? | () | () |
| H. Have you ever given your child fluoride vitamins or tablets? | () | () |
| I. Do you supervise your child's cleaning procedure? | () | () |
| J. Does your child use dental floss? | () | () |
| K. How often does your child brush daily? _____ | | |
| L. What type of toothpaste is used? _____ | | |

IV. PERMISSION

I (we) hereby give authorization as a parent or guardian to Scott H. Leaf, D.D.S. & Associates for the completion of all agreed upon dental services for my child or children, and agree to become personally responsible for such financial obligations incurred.

Signature _____
 Parent/Guardian's Social Security Number _____
 Parent/Guardian's Birthdate _____
 Date _____