

Children's Dentistry of Apex ♦ Ronald Venezie, DDS, MS, PA

Child's Name _____ Date of Birth _____ / _____ / _____

Health History

Child's Physician _____ Phone # (_____) _____ Date of last exam _____

Circle One

Yes No Has your child ever had a health problem? Please explain. _____

Yes No Has your child ever been hospitalized? Please give reason(s) and date(s). _____

Yes No Is your child allergic to anything? _____

Yes No Is your child currently taking any medications? Please list medication(s) and reasons(s). _____

Yes No Were there any problems at birth? _____

Yes No Was your child breast fed? If so, at what age was it stopped? _____

Yes No Was your child bottle fed? If so, at what age was it stopped? _____

Has your child been treated for any of the following?

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Autism
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Learning disability	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> AIDS	<input type="checkbox"/> Speech disorder	<input type="checkbox"/> Emotional disorder
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Brain injury	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hearing disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cleft lip/palate	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Vision disorder	<input type="checkbox"/> Other (explain)

Please explain any past health problems we should be aware of. _____

Dental History

Circle One

Yes No Has your child ever been to the dentist? Date of last visit. _____

Name and phone number of dentist. _____

Yes No Has your child had any unfavorable reaction to previous dental care? Please explain. _____

Yes No 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 noises, and is pain associated with the sounds?

Yes No Is your drinking water fluoridated?

Yes No Does your child use a fluoride toothpaste?

Yes No Do you give your child any other form of fluoride? If so, what? _____

Consent for Dental Treatment

I request and authorize Dr. Ronald Venezie to examine, clean and provide dental treatment for my child's teeth. I further request and authorize the taking of dental radiographs (x-rays) as Dr. Venezie may consider necessary to diagnose and or treat my child's dental problem(s). 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. Venezie will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, demonstration of procedures and instruments and use of variable voice tone.

Signature _____ Relationship to patient _____ Date _____