PEDIATRIC DENTISTRY of Ft. Myers

General Information

TIM M. VERWEST, DMD
P: 239.482.2722 | F: 239.482.7877
8016 Summerlin Lakes Drive | Ft. Myers, FL 33907

DATE _____

Parent or Guardian _____ Parent or Guardian _____
Relationship _____ Relationship _____
Home Address _____
City _____ State _____ Zip Code _____
Home Phone _____

Father's Occupation _____ Social Security # _____
Employed by _____ Address _____ Phone _____
Mother's Occupation _____ Social Security # _____
Employed by _____ Address _____ Phone _____

Whom may we thank for referring you? _____

CHILD'S INFORMATION

Name _____ Nickname _____
Birthdate _____ Age _____ Gender : ☐ M ☐ F
Attends what school? _____ Grade: _____ Social Security # _____
Names and ages of brother and sisters _____
Child's Physician or Pediatrician and address _____
PARENTS' adult dentist _____

MEDICAL HISTORY

Has your child experienced any of the following?

	YES	NO		YES	NO
Allergic	____	____	Hepatitis	____	____
Anemia	____	____	Endocrine Disease	____	____
Asthma	____	____	Kidney Disease	____	____
Bleeding Disorder	____	____	Liver Disease	____	____
Bronchitis	____	____	Lung Problems	____	____
Behav/Learning Problem	____	____	Mental Disorder	____	____
Diabetes	____	____	Nervous Disorder	____	____
Epilepsy	____	____	Rheumatic Fever	____	____
Fainting	____	____	Seizures	____	____
Hearing Disorder	____	____	Speech Disorder	____	____
Heart Disease	____	____	Tonsils/Adenoids	____	____
Frequent Headaches	____	____	Birth Defects	____	____
Cancer/Tumors	____	____	Blood Transfusions	____	____
Frequent Infections	____	____			

Do you need communiaiton assistance (Braille, TTY, sign language)? ☐ Yes ☐ No

Patients Primary Language? _____

If 18 years or older, do you have an Advanced Directive (Living Will) ? ☐ Yes ☐ No

Has your child been hospitalized, and if so, when?

_____

Patient Name: _____ **Account #:** _____

Has your child ever had anesthesia?

Has your child ever suffered any significant injuries, and if so when?

When was your child's last physical examination?

Other physical or mental disorders?

Is your child taking any medication at this time? List if any:

Has your child had any unfavorable reaction or allergy to any medication such as penicillin, aspirin, or novacaine? List if any: _____

I certify that I have read and understand the above. I acknowledge that the questions above have been answered to my satisfaction. 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 competion of this form. I have received written information regarding advanced directives. (If applicable)

_____ _____

Signature of Patient/Legal Guardian **Date**

DENTAL HISTORY

Has your child been to a dentist? If so, when? _____

Does or has your child suffered from any TMJ/TMD problems? _____

Is your child now or have they used fluoride? If so, when and what kind of fluoride? _____

When was your child take off the bottle? _____

1. What are your concerns about your child's dental health?

2. If there is any information that you feel might be of value to us in the treatment of your child please add it here:

3. In general, most children are cooperative and have good behavior during treatment, would you predict your child's behavior to be (circle all that would apply):

Don't know	**Cooperative**	**Fearful**
Stubborn	**Apprehensive**	**Defiant**

4. When treatment requires local anesthesia (numbness) we often use nitrous oxide (laughing gas) in addition to anesthesia to relax the patient and make treatment easier.

5. Are there any items you would like to discuss with us? Please list:

I authorize the dentist to release any information including the diagnosis and the records of treatement or examination rendered to my child during the period of treatment.

_____ _____

Signature of Patient/Legal Guardian **Date**