

Golnick Pediatric Dental Associates

21213 Ecorse Road
 Taylor, MI 48180
 313-292-7777
 Fax (313) 292-7515

2300 Haggerty Road #1180
 West Bloomfield, MI 48323
 248-668-0022
 Fax (248) 668-2162

Welcome to our office. It is important to completely fill out this questionnaire for your child. All information is confidential and will not be released to anyone without your consent. Please print clearly. Any question, please ask. Thank you.

Child's Personal Information

Child's Name (last) _____ (first) _____ (nickname) _____
Date of Birth _____ **Gender** (circle one): male female **Weight** _____
Physician (Name) _____ (City) _____ (Phone) _____
Pharmacy (Name) _____ (City) _____ (Phone) _____
Child's Favorite (Sport) _____ (Toy) _____ (Hobby) _____

Child's Medical Health Evaluation

Please circle Yes or No for each question

- Yes No 1. Is your child in good health? Date of last medical exam? _____
 Yes No 2. Is your child currently under the care of a physician?
 If yes, for what? _____
 Yes No 3. Has your child ever been hospitalized for any serious illnesses? Any surgery performed?
 If yes, please explain _____
 Yes No 4. Is your child allergic to or had an allergic reaction to any drugs, medications, or latex?
 If yes, please specify _____
 Yes No 5. Is your child taking any prescription or non-prescription drugs, medicines, or pills?
 If yes, please specify _____
 6. Does your child have or had any of the following diseases, illnesses or medical problems?

Heart Murmur / Rheumatic Fever	Yes	No	Thyroid Problems	Yes	No	Sinus Problems	Yes	No
Kidney Problems / Urination	Yes	No	Blood Disorders / Anemia	Yes	No	Seizures / Epilepsy	Yes	No
Hepatitis / Liver Problems	Yes	No	Asthma / Breathing / TB	Yes	No	Diabetes / Sugar	Yes	No
Attention Deficit Disorder (ADD)	Yes	No	Hyperactivity	Yes	No	Colitis / Ulcer	Yes	No
Deafness / Hearing	Yes	No	Blindness / Vision	Yes	No	Heart Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Artificial Joints / Pins	Yes	No	Herpes / Cold Sores	Yes	No
Premature Birth	Yes	No	Complications at Birth	Yes	No	Cancer / Tumors	Yes	No
Radiation therapy (x-rays)	Yes	No	Reflux / Stomach Disorders	Yes	No	Prolonged bleeding	Yes	No

- Yes No 7. Has your child ever been exposed or diagnosed with HIV or AIDS?
 Yes No 8. Has your child ever had to seek psychological or psychiatric counseling?
 Yes No 9. Does your child smoke or use smokeless tobacco? If yes, how many packs / day? _____
 Yes No 10. Does your child have a learning disability or attend a special school?
 If yes, please explain _____
 Yes No 11. Any further comments regarding your child's medical condition we should know about?
 If yes, please explain _____
 Yes No 12. Is your child pregnant? If yes, when in the expected due date? _____

Are there any additional comments regarding your child's medical health you would like to share with us?

Continued on next page

Child's Dental History

Why did you bring your child to our office today? _____

Please circle Yes or No for each question

- Yes No 1. Is this your child's first visit to a dentist?
If no, when was last dental visit? _____ Dentist's name? _____ (city) _____
- Yes No 2. Is your child complaining of any discomfort at this time?
If yes, please explain _____
- Yes No 3. Has your child ever had a filling or tooth removed?
- Yes No 4. Has your child ever received local anesthetic ("had their tooth put to sleep")?
If yes, what was their reaction? _____
- Yes No 5. Has your child ever had nitrous oxide (laughing gas)?
- Yes No 6. Does your child have any loose teeth?
- Yes No 7. Does your child's gums bleed when they brush / floss?
- Yes No 8. Do you brush your child's teeth? If yes, how often? _____
- Yes No 9. Does your child brush his/her own teeth? If yes, how often? _____
- Yes No 10. Do you or your child use dental floss when cleaning the teeth? If yes, how often? _____
- Yes No 11. Does your child snack in between meals? Favorite snack(s)? _____
- Yes No 12. Does your child have any popping, clicking or pain around their ears or jaw joint?
- Yes No 13. Does your child grind or clench their teeth? If so, when? _____
- Yes No 14. Any past or planned orthodontic treatment (i.e. braces)? Name of Orthodontist? _____
- Yes No 15. Does your child have any oral habits? Pacifier Nursing Bottle Thumb / finger sucking Nail biting
- Yes No 16. Does your child have any speech problems? If yes, explain _____
- Yes No 17. Is your drinking water filtered, from a well, or from a bottled source?
- Yes No 18. Does your child use fluoride? Please circle: Tablets Vitamins Toothpaste Varnish Professional topical applications
- Yes No 19. Does your child participate in contact sports (i.e. hockey, soccer, football, etc.)?
- Yes No 20. Any unhappy dental experiences? If yes, explain _____
- Yes No 21. Do you anticipate your child having difficulty accepting dental treatment?

Any additional comments _____

I agree that my child's physician and/or previous dentist may be contacted to complete details of their medical and dental histories , if required. _____ Parent / Guardian initials

OFFICE POLICY

Your appointment time will be reserved especially for you and your child. If you are unable to keep your appointment, we require 24 hours notice, otherwise it may be necessary to charge you for the lost time.

Payment is due at the time services are provided, unless other arrangements have been made prior to the beginning of treatment. We gladly accept payment from your dental insurance, however, you are ultimately responsible for all dental charges. It is your responsibility to understand your own insurance coverage, deductibles, and eligibility.

CONSENT FOR DENTAL TREATMENT

The information completed on this form is correct to the best of my knowledge. I (parent / guardian) _____ understand that all medical and dental information will be held in confidence. I hereby consent to the performing of dental procedures necessary or advisable for my child (name) _____, and I accept responsibility for the charges. I agree to the office policy as stated.

Parent / Guardian Signature _____ **Date** _____

HEALTH HISTORY UPDATE

Have there been any changes in your child's health or medications since the last update?

- Yes No Date _____ Comments _____ Signature _____
- Yes No Date _____ Comments _____ Signature _____
- Yes No Date _____ Comments _____ Signature _____
- Yes No Date _____ Comments _____ Signature _____