Mount Auburn Dental
Youth Health History 2017

Thank you for providing us with the necessary confidential information which will help us to know your child/young adult and make his/her visits with us more enjoyable.

Child's Name:_____ Date of Birth: _____ Sex: M F
Primary Address: _____ Phone: _____ Cell: _____
Is this their first visit to the dentist? Y N Former Dental Office: _____

Parent/Guardian Information
Mother's Name: _____ Father's Name: _____
Child lives with: ___Both ___ Mom ____ Dad ___ Other: _____
Adult responsible for charges: _____
Dental Insurance: _____ Subscriber: _____
Insured Date of Birth: _____ Employer: _____

Please give your insurance card at the front desk to copy for our records.

Your child's overall health, as well as any medications (prescription OR over-the-counter) could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Is your child in good health? Y N _____
Name of your child's pediatrician: _____
Pharmacy: _____

Is your child allergic to any of the following: Please CIRCLE any that apply.
Aspirin Penicillin Amoxicillin Codeine Latex Local Anesthetics
Other: _____
Have you ever been told your child needs to be pre-medicated before a dental visit? ___Y ____N

List ALL medications including over-the-counter medication that your child is currently taking:

_____

_____

Please check all that apply to your child currently OR in the past:

__ AIDS/HIV
__ Asthma
__ Arthritis or joint disease
__ Anemia or Blood Disorders
__ Accidents or Severe Infections
__ Dental Phobia
__ Diabetes
__ Epilepsy, Seizure, or Fainting issues
__ Glandular or Hormonal Problems
__ Heart Trouble
__ High/Low Blood Pressure
__ Hepatitis
__ Kidney/Bladder Problems
__ Latex Allergies
__ Liver Problems, Jaundice
__ Psychological or Emotional Problems
__ Prolonged Bleeding
__ Sensitive Gag Reflex
__ Tuberculosis
__ Any pending or recent surgery: _____
_____

Does your child brush his/her own teeth? __Y __ N Do you assist your child in brushing? __Y __ N
Is your home water supply Fluoridated? __Y __ N Is your child's toothpaste fluoridated: __Y __ N
Does your child us a fluoride supplement? __Y __ N Dose: __0.25mg __0.50mg __1.00mg
Do you give your child any other form of fluoride? What:_____ Amount: _____

Consent for Dental Treatment

I request and authorize Dr. James Helmkamp and his staff to examine, clean and provide my child with comprehensive dental treatment. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Helmkamp to diagnose and/or treat my child's dental condition. 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. Helmkamp will provide an environment likely to help children/young adults learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I agree that I will remain on site during my child's dental appointment.
I hereby certify that all of the information supplied is correct and true. I understand that I will be responsible for any and all charges incurred by this child for dental treatment.

_____ _____

Signature Date

Thank you for entrusting your child's dental care to us. We will do our best to see that your child is comfortable and acquires the knowledge she/he will need to help them to keep their teeth for the remainder of their lives. Through discussions of making better choices for their dental health and great dental care, along with your support we can give them a smile to last a life time!

Please use this space for any addition information that you think we should be made aware:

_____

_____

_____

_____