Welcome to Mount Auburn Dental….and Dr. Jim

Medical History/ Information Form

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

Is this your child's first visit to a dentist? __ Y __ N Former Dentist: _____
How long since last visit? _____ Dental Concerns: _____
_____

Child's Name: _____ DOB: _____ Sex: __ M __ F
Primary Address: _____ Home Phone: _____
Child's favorite Hobbies/ Interests: _____ Cell Phone: _____

Parent/Guardian Information
Mother's Name: _____ Father's Name: _____
Child Lives with: ___ Both ___ Mom ___Dad ___ Other: _____
Adult responsible for charges: _____
Dental Insurance: _____ Subscriber: _____
DOB of Subscriber: _____ Employer: _____

Please give your dental insurance card to front desk to copy

We are happy to submit your dental claims to your insurance and will do everything we can to see that you receive the benefits you are entitled to however, this is YOUR insurance. If your insurance company has not paid on your claim within 45 days, the FULL balance will automatically be transferred to you. You are responsible to seeing that we have your current dental insurance on file. Thank you.

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

Habits and Personality

Does your child have any of these habits?
__ Finger or Thumb Sucking __ Mouth Breathing __ Tongue Thrust
__ Clenching or grinding teeth __ Nail Biting

Please check all the words that seem to best describe your child:
__ Calm __High-Strung __ Spoiled __ Active __ Cooperative __ Quiet __ Moody __ Shy
__ Curious __Fearful __ Friendly __ Helpful __ Talkative __ Prone to Temper Tantrums

Does your child brush his/her own teeth? __ Y __ N
Do you assist your child in brushing? __ Y __ N Does your child floss? __ Y __ N
Is your home water supply fluoridated? __ Y __ N Does your child use fluoride toothpaste? __Y __N
Does your child use a fluoride supplement? __Y __ N Dose: __0.25mg __0.50mg __ 1.00mg
Do you give your child any other form of fluoride? _____
Does your child snack between meals? ___ Y ___ N

Turn the page over to complete the medical history

Health History

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

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 requires pre-medication before a dental visit? __ Y __ N
What pharmacy do you use: _____ Where: _____

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:

__ Asthma	__ Dental Phobia	__ Latex Allergy	__ Accidents or Severe Infections
__ Hepatitis	__ AIDS/HIV	__ Tuberculosis	__ Psychological or Emotional Problems
__ Heart Trouble	__ Diabetes	__ Prolonged Bleeding	__ Liver Problems, Jaundice or Hepatitis
__ Kidney/Bladder Problems		__ Nervous Disorder	__ Epilepsy, Seizure, or fainting issues
__ Anemia or Blood Disorder		__ Arthritis or Joint Disease	__ High/Low Blood Pressure
__ Sensitive Gag Reflex		__ Glandular or Hormonal Problems	

__ Pending or recent surgery _____

<u>Consent for Dental Treatment</u>:
I request and authorize Dr. James Helmkamp, and his hygienists 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 <u>necessary</u> 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 learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I further agree that I will remain on site during my child's dental appointment.

I hereby certify that all the information supplied is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all dental treatment can commence. I understand that I will be responsible for any and all charges incurred by my child's dental treatment.

_____ _____
Signature of Parent/Guardian **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 keep their teeth for the remainder of their lives through information to make better choices for their dental health and great dental care!