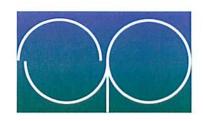
Do you consider your child to be		<ul> <li>advanced in the learning process</li> <li>progressing normally</li> <li>slow in the learning process</li> </ul>					
Was your child	□ breast fed			vas it stopped?			
Dental History							
☐ Yes ☐ No	Has your child ever been to the dentist? Date of last xrays (if taken)  Name of dentist and date						
☐ Yes ☐ No	Has your child experienced any unfavorable reaction from previous dental care? 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 noise and is pain associated with the sounds?						
Please check if your child is having problems with any of the following:							
<ul><li>□ Cavities</li><li>□ Trauma</li><li>□ Orthodontics</li></ul>	□ G	Toothache					
Comments:							
	14	Fluoride History		Office Use Only  ☐ FI- City Water			
☐ Yes ☐ No	Is your home wat	er supply fluoridated?		☐ Pvt. Well ☐ Public Wellppm			
☐ Yes ☐ No	Does your child u	se a fluoride toothpaste	?	☐ H₂O test kit given			
☐ Yes ☐ No	Do you give your child any other form of fluoride? What?						
☐ Yes ☐ No	Does your child participate in a school fluoride rinse program?						
Consent for Dental Treatment							
further request and to diagnose and/or child's teeth for dia includes efforts to appropriate for the cooperate during trinstruments, and us for dental treatments.	d authorize the takin treat my child's dent agnostic or education guide their behavior eir age. Dr. Conn will reatment by using pro sing variable voice to	camine, clean, and provide of g of dental x-rays as may lead problem. I will allow photal purposes. I understand by helping them to unders provide an environment like aise, explanation and demonde. I will be responsible for	be consider of the consider of the constant of the constant of the constant of the construction of the con	to be taken of my child or all treatment for children reatment in terms children learn to f procedures and ges incurred on this child			
Signature				Date			

## ADULT & CHILD ORTHODONTISTS



## PEDIATRIC DENTISTS

## Michael J. Mayhew, DDS,MS,PA Diplomate, American Board of Orthodontics Diplomate, American Board of Pediatric Dentistry

Stacy A. Conn, DMD Diplomate, American Board of Pediatric Dentistry

Nicole Scheffler, DDS,MS Diplomate, American Board of Orthodontics Martha V. Hardaway, DMD, MS Diplomate, American Board of Pediatric Dentistry

	Demogra	phic Information					
Patient			Today's Date				
Name child would	like to be called		Home Phone				
BirthdayAge		Sex	exCell Phone				
Guardian's Email							
Home Address_							
	street	town	state	zip code			
	of other children in family						
School			Grade				
			Relation to patient				
EmployerPhone							
Guardian 2:Relation to patient							
Employer		Phone					
the state of the s	1 1		Dental Insurance: 🗆 Yes 🗔 No				
	e for payment of account_						
	hysician/group						
	ank for referring you to us						
What is the reason	on for your child's dental v	isit?					
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Is your child in good hed  Yes No Has y Has your child ever been	your child ever had a n hospitalized? Pleas	health problem?_ se give reason and				
	Is your child allergic to anything?						
☐ Yes ☐ No	es $\  \  \  \  \  \  \  \  \  \  \  \  \ $						
1 Yes No	Were there any problem	oc at hinth?					
1762 1100	were mere any problem	is at birth?					
☐ Heart disease ☐ Liver/GI disease ☐ Kidney disease ☐ Speech/hearing ☐ Eyesight ☐ Cancer/tumors ☐ Cerebral palsy	Dur child has been treated  Bleeding/transfusions Anemia Rheumatic fever Seizures Congenital birth defects Recurrent headaches Sianificant injuries on any items circled:	for any of the follow  Asthma/breathing Diabetes Hepatitis Cleft lip/palate Personality/social Frequent infections Endocrine/arowth					
	,			D 19 1919			
Office use only							