Welcome to the office of

Loren C.Baim, D.D.S.

Date _____

Child's Name _____ Sex _____ Age _____ Date of Birth _____

Street Address _____ City _____ Zip Code _____ Child's Weight _____

Child's S.S.# _____ School: _____ Grade _____

Father's Name _____ Address: _____ Phone _____

Employed By _____ Position _____ Work Phone _____

Mother's Name _____ Address _____ Phone _____

Employed By _____ Position _____ Work Phone _____

Referred By _____ Purpose of Call _____

Who will pay for this account? _____

Name(s) of Dental Insurance Co.(s):

Mother's _____ S.S.# _____ Group # _____ D.O.B. _____

Father's _____ S.S.# _____ Group # _____ D.O.B. _____

Have any other members of your family been treated in our office? yes _____ no _____

Names and ages _____

Emergency Contact (other): _____ (Relationship) _____ Phone _____

The Policy of Office Is The Parent/Guardian Who Requests Treatment For The Child Is Responsible For All Fees For Services Rendered.

Signature and Relationship of Adult Requesting Care _____ Date _____

Medical History

General Health: Excellent ____ Good ____ Fair ____ Poor ____

Date of Last Medical Exam _____

Is the Child Under the Care of a Physician? _____

If So, for What? _____

Physician's Name? _____ Phone _____

Has the Child Ever Had:

Anemia Yes ____ No ____

Diabetes Yes ____ No ____

Hepatitis Yes ____ No ____

Kidney Disease Yes ____ No ____

Asthma Yes ____ No ____

Allergies Yes ____ No ____

Allergic to Penicillin Yes ____ No ____

Allergic to Local Anesthetic Yes ____ No ____

Abnormal Heart Condition Yes ____ No ____

Heart Condition Yes ____ No ____

Heart Murmur Yes ____ No ____

Rheumatic Fever Yes ____ No ____

Abnormal Bleeding from a Cut Yes ____ No ____

Any Medications Being Taken Yes ____ No ____

Please List _____

Other Physical Conditions You Feel are Important _____

_____

Dental Health

Date of Last Dental Exam _____

Dentist's Name _____

Address _____

What Was Done? _____

Has the Child Ever Had a Serious Problem Associated with a Previous Dental Visit? Yes ____ No ____

Explain _____

How Often Does the Child Brush _____ Floss _____

Mouth Habits:

Thumbsucking _____ Mouth Breathing _____

Bottle, Nursing _____ Grinding Teeth _____

Does Child Usually Have Many Cavities? Yes ____ No ____

Has Child Had Teeth Removed? Yes ____ No ____

Has Child Had Orthodontic Treatment? Yes ____ No ____

Has Child Received Any Fluoride Yes ____ No ____

Pills/Vitamins ____ Topical ____ Water ____

Does Child Gag Easily? Yes ____ No ____

Does Child Have Dental Pain? Yes ____ No ____

Please Add Anything You Feel Is Important _____

_____

_____