

Paul I. Rubin, D.D.S., P.A.

Frisco Kids Dentistry

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Demographic Information

Patient _____ Today's date _____
Patients preferred name _____ Date of Birth _____
Age _____ Sex _____ Home phone _____

Whom may we thank for referring you to our practice? _____

Home address _____
Street City Zip code

School _____ Grade _____

Mother _____ email/phone _____

Mother's employer _____ work phone _____

Father _____ email/phone _____

Father's employer _____ work phone _____

Who has legal custody of child? _____

Person responsible for payment of account _____ SS#/DOB _____

Dental Insurance: ___Yes ___No Carrier _____

Health History

Yes No Is your child in good health? Name of child's physician _____
Phone _____ Date of last medical checkup _____

Yes No Has your child ever had any health problems? _____

Yes No Has your child ever been hospitalized? If so, list why and date _____

Yes No Is your child allergic to anything (food/drugs/dye/latex, etc)? _____

Yes No Is your child currently taking any medication (including OTC). If so, please list with
the dosage. _____

Yes No Were there any problems at birth? _____

Please Check if your child has been treated for any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer/ Tumors | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Physical Delays |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital Birth Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Recurrent Headaches |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Dyscrasia | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding/ Transfusions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver | <input type="checkbox"/> Speech/ Hearing |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Personality/ Social | <input type="checkbox"/> Other |

Please elaborate on ANY items marked:

OVER PLEASE

Do you consider your Child to be:

- advanced in the learning process progressing normally slow in the learning process

Was your child: Breast fed Bottle fed At what age was it stopped? _____

Dental History

Yes No Has your child ever been to the dentist? 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:

- Cavities Toothache Teeth Sensitive Jaw Sounds
 Trauma Gum Infections Color of Teeth Orthodontics
 Other _____

Fluoride History

Yes No Is your home water supply fluoridated?

Yes No Does your child use a fluoride toothpaste?

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

I request and authorize Dr. Rubin to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Rubin to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or education purposes. 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. Rubin 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 will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent or Legal Guardian _____