

(Continued)

DENTAL HISTORY

	YES	NO
Have there been any injuries to your child's teeth? How? _____	()	()
Does your child have any oral habits, thumb/finger sucking, or lip biting? _____	()	()
Is this your child's first visit to the dentist? Last dental visit? _____	()	()
Will your child be a cooperative dental patient? Explain: _____	()	()
Does your child take fluoride or vitamins with fluoride? What? _____	()	()
Has your child inherited any family dental characteristics? What? _____	()	()
Please <u>circle</u> any of the following dental problems that your child has had:		
Cavities	Teeth Bumped	Toothache
Teeth sensitive to sweets	Color of Teeth	Crooked Teeth
Teeth sensitive to hot or cold		
Have there been any other dental problems? Explain _____	()	()
If your child was bottle fed, at what age did your child give it up completely? _____		
Please <u>circle</u> reason or reasons for visiting our office today:		
Decay	Habit	Crooked Teeth
Checkup	Behavior	Discolored Teeth
Emergency	Physical or Mental Handicap	Other _____

To the best of my knowledge, all of the preceding answers are true and correct. If there ever are any changes in the patients health, or if there's a change in medication, I will inform the doctor at the next appointment.

Permission is hereby granted to A.J. Brandtner, DDS and his staff, after parent/guardian consultation, to do all such things as may be necessary to diagnose, treat and care for the needs of _____ who is a minor and under the care of his/her parent(s) or legal guardian.

Permission is also given to Dr. Alex Brandtner and his staff to furnish any insurance company, welfare or relief organization any and all information with respect to any illness or injury, medical history, consultation or treatment or copies of any with respect to such child.

All services are provided on a cash basis only unless other arrangements are made. As a special service to our patients, we will submit your dental claims to your insurance company at no charge, if we are provided with an insurance claim form with an appropriate mailing address. However, parents or guardians are responsible for their own account, including, if necessary, following up on claims to assure prompt processing and payment.

Date _____ Signature of Patient's Parents or Guardian _____