THE CHILDREN'S DENTAL CLINIC
PO Box 660
Paoli, PA 19301-9997
610-240-1213

To Parent/Guardian:

The information requested on this form is needed by The Children's Dental Clinic to consider dental treatment for your child. Please complete and return to the address above (PO Box 660, Paoli, PA 19301-9997) as soon as possible.

TODAY'S DATE:_____

Is your child covered by dental insurance? NO YES Name of Insurance Company:_____

Has your child previously been treated at The Children's Dental Clinic? NO YES Year(s) treated_____

CHILD'S SCHOOL NAME:_____ GRADE:_____

CHILD'S NAME:_____ Please indicate: M or F BIRTHDATE:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

HOME PHONE:_____ CELL:_____ E-MAIL:_____

Answers to the following questions are for our records only and are confidential. Please answer YES or NO, and fill in blank spaces.

1. Is your child in good health---------- YES NO
    a) Has there been any change in his/her general health within the past year---------- YES NO
2. My child's last physical examination was on_____
3. Is he/she now under the care of a physician---------- YES NO
    a) Why_____
    b) Physician name, phone number_____
4. Has he/she had a serious illness or operation---------- YES NO
    a) Illness/Operation_____
5. Does he/she have or have had any of the following diseases or problems:
    a) Rheumatic fever or rheumatic heart disease---------- YES NO
    b) Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)---------- YES NO
    c) Asthma or hay fever---------- YES NO
    d) Allergy---------- YES NO
    e) Hives or skin rash---------- YES NO
    f) Fainting spells or seizures---------- YES NO
    g) Diabetes---------- YES NO
        1) Does he/she urinate (pass water) more than six (6) times a day---------- YES NO
        2) Is he/she thirsty much of the time---------- YES NO
        3) Does his/her mouth frequently become dry---------- YES NO
    h) Hepatitis, jaundice or liver disease---------- YES NO
    i) Arthritis---------- YES NO
    j) Inflammatory rheumatism (painful swollen joints)---------- YES NO
    k) Stomach ulcers---------- YES NO
    l) Kidney trouble---------- YES NO

(over, please)

m) Tuberculosis---------- YES NO

n) Does he/she have a persistent cough or cough up blood---------- YES NO

o) Low blood pressure---------- YES NO

p) High blood pressure---------- YES NO

q) Venereal disease---------- YES NO

r) Psychiatric treatment---------- YES NO

6. Has he/she had abnormal bleeding associated with previous extractions, surgery or trauma---------- YES NO

a) Does he/she bruise easily---------- YES NO

b) Has he/she ever required a blood transfusion---------- YES NO

7. Does he/she have any blood disorder such as anemia---------- YES NO

8. Has he/she had surgery, or radiation or chemotherapy for a tumor, growth or other condition---------- YES NO

9. Is he/she taking any of the following:

a) Antibiotics or sulfa drugs---------- YES NO

b) Anticoagulants (blood thinners)---------- YES NO

c) Medication for high blood pressure---------- YES NO

d) Cortisone/steroids---------- YES NO

e) Tranquilizers---------- YES NO

f) Aspirin---------- YES NO

g) Insulin, tolbutamide (Orinase) or similar drug---------- YES NO

h) Other_____

10. Is he/she allergic or reacted adversely to:

a) Local anesthetics---------- YES NO

b) Penicillin or other antibiotics---------- YES NO

c) Sulfa drugs---------- YES NO

d) Barbiturates, sedatives or sleeping pills---------- YES NO

e) Aspirin---------- YES NO

f) Iodine---------- YES NO

g) Latex---------- YES NO

h) Other_____

11. Has he/she had any serious trouble associated with any previous dental treatment---------- YES NO

If so, please explain_____

12. Does he/she have any disease, condition or problem not listed above we should know about---------- YES NO

If so, please explain_____

13. Is your student under the care of a district aide---------- YES NO

By signing below, you understand and agree that:

- **If extensive or special work is needed, your child may be referred to a local dentist who volunteers his/her services.**
- **The charge for each visit to the Children's Dental Clinic is $10.00. Please make payments promptly. If it becomes impossible for you to pay, it is your responsibility to let us know. Checks made payable to *The Children's Dental Clinic* can be mailed to The Children's Dental Clinic, PO Box 660, Paoli, PA 19301.**
- **Your child's transportation to and from the clinic (or other locations as prescribed) must be provided or arranged by you, the parent. However, if arranging transportation presents a hardship, the Children's Dental Clinic may be able to provide a volunteer driver. If a volunteer driver is required, you give permission for that driver to transport your child to his/her appointment, you assume all liability and risk, and you waive all claims, release, indemnify, and hold harmless the Children's Dental Clinic (and its volunteer driver) from liability for any injuries or damages that occur during transportation.**

PARENT/GUARDIAN SIGNATURE:_____Date:_____

Please print name:_____

Return this completed form to: The Children's Dental Clinic, PO Box 660, Paoli, PA 19301-9997