Rosenbaum DENTAL

DAVID ROSENBAUM, DDS
2201 S. HWY 51, SUITE 300
DECATUR, TEXAS 76234
(940) 626-0003

Child's name_____

Nickname_____

Birthdate_____

School_____

Child's home address_____

City_____State_____Zip_____

Phone Number_____

***Mother***

Name_____

Cell phone_____

Other phone_____

SS#_____

Employer_____

***Father***

Name_____

Cell phone_____

Other phone_____

SS#_____

Employer_____

DL#_____

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***Child's Health History***

Child Habits

How often does your child brush?_____

How often does your child floss?_____

Date of last dental visit?_____

Previous Dentist_____

Child's physician_____

Physician's phone number_____

Is your child's water fluoridated yes ☐ no ☐

Thumb sucking yes ☐ no ☐

Suck/bite lip yes ☐ no ☐

Bite/chew nails yes ☐ no ☐

Grind teeth yes ☐ no ☐

Clench jaws yes ☐ no ☐

Health history

Has your children has difficulty with previous visits? yes ☐ no ☐

Does your child have a persistent cough or throat clearing? yes ☐ no ☐

Does your child have any of the following?

Asthma yes ☐ no ☐ Rheumatic fever yes ☐ no ☐

Cancer yes ☐ no ☐ Congenital heart defect yes ☐ no ☐

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Does your child have any of the following? *(continued)*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hepatitis | yes ☐ | no ☐ | | Tuberculosis | yes ☐ | no ☐ | |
| Handicaps/Disabilities | yes ☐ | no ☐ | | Diabetes | yes ☐ | no ☐ | |
| HIV/AIDS | yes ☐ | no ☐ | | Abnormal Bleeding | yes ☐ | no ☐ | |
| Convulsions/Epilepsy | yes ☐ | no ☐ | | Allergies | yes ☐ | no ☐ | |
| Hemophilia | yes ☐ | no ☐ | | Heart murmur | yes ☐ | no ☐ | |

List all medications your child is currently taking:

_____

List all allergies (food/medication):

_____

Please explain any medical problems that your child has:

_____

***Authorization and Release***

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

*Signature of patient (or patient/guardian of minor)*