CHILDREN'S DENTAL SPECIALISTS, PA

CHRISTINA MAZZONE * DMD
MADHU MOHAN * DMD

Child's Name ________________________________ Age_______ Date _____________
Last First

Child's Date of birth ____________ ❍ Male ❍ Female Height _______Weight________

School ___________________________ Grade ___________

Nickname________________________ Hobbies ___________________________________

Address ____
City State Zip Code

Home Phone # _____________________ Cell/Pager # ______________________________

Pediatrician ____
Name Address Phone

Whom may we thank for this referral / How did you hear about us?_____________________________

Reason For Today's Visit ____

Mother's information:

Name _______________Date of birth______

Address______________________________

Employer_____________________________

Occupation ___________________________

Business Phone ________________________

Home Phone___________________________

Cell Phone____________________________

Email________________________________

Father's Information:

Name ________________Date of birth______

Address______________________________

Employer_____________________________

Occupation ___________________________

Business Phone ________________________

Home Phone___________________________

Cell Phone____________________________

Email________________________________

☐ Please check if you prefer to be notified by email

General Health Status: ❍ Excellent ❍ Good ❍ Fair

Date and reason for child's last medical exam____

Has your child ever been hospitalized?
Reason____

Is your child allergic to any medicine, food, or substance?
List____

Is your child taking any medications?
List____

Has your child ever had any of the following? Please check

__Heart Murmur	__Asthma	__Chronic Sinusitis	__Lung Disease
__Heart Disease	__Anemia	__Cerebral Palsy	__Seizures
__Hepatitis	__Bronchitis	__Bleeding Problems	__Epilepsy
__Diabetes	__Tuberculosis	__Blood Transfusion	__Other
__HIV (+) or AIDS	__Thyroid	__Hearing Difficulty	______________
__Kidney disease	__Hemophilia	__Liver Disease	

Has your child's physical development been normal? ___Yes ___No
If no, please explain____

Does your child have any Psychological/Emotional/Behavioral concerns? ___Yes ___No
If yes, please explain____

Has your child ever been diagnosed with the following: ADD__ PDD__ ADHD__ Autism__ None __

Is this your child's first visit to the dentist? ___Yes ___No

Name, and date of last visit at previous dentist? ____

Reason for that visit?_______________________________ Were X-rays taken? ___Yes ___No

Does your child have any oral habits? Please check all that apply:

___ Pacifier ___Finger/thumb habit ___Nail biting ___Tongue thrust

___Grinding teeth ___Other __________________________________

Are you happy with the appearance of your child's teeth? ____Yes ____No please explain:
____

Does your child take fluoride in any form? ____