DAVID M. SULLIVAN, D.D.S., M.S.®

pediatric dentistry

Building a lifetime of healthy smiles!

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These questions are of great value in aiding us to a better understanding of your child.

Child's Name _____ Nickname, if any or name child likes to be called _____

Birthdate _____ Male or Female _____ Hobbies _____ Age _____

Attending what school _____ E-mail _____ Grade _____

Home Address _____ City, State, Zip _____

Home Phone Number _____ Mobile _____ Physician or Pediatrician _____

Any other emergency contact _____

Family Dentist _____

Whom may we thank for referring you to our office _____

Name and ages of Brothers and/or Sisters _____

Name of insurance plan. Medical _____ Dental _____

Secondary insurance. Medical _____ Dental _____

Father's Full Name _____ Employed by _____

Work Phone _____ Cell _____ Social Security No. _____ Birthdate _____

Mother's Full Name _____ Employed by _____

Work Phone _____ Cell _____ Social Security No. _____ Birthdate _____

Person Responsible for Account if other than above _____

Address _____ City, State, Zip _____

MEDICAL INFORMATION: PLEASE RESPOND TO EVERY QUESTION

A. Has your child ever been hospitalized or been in a hospital? _____

Emergency Room? _____ If yes, why? _____

B. Is your child under the care of a physician? _____ If yes, why? _____

C. Is your child taking any medications? _____ If yes, what? _____

D. Is your child allergic to anything? _____ If yes, what? _____

E. Has your child ever had a reaction to penicillin or any other drug? _____ If yes, what drug? _____

F. Does your child use fluoridated water at home? ☐ Yes ☐ No Cincinnati Water ☐ Yes ☐ No

Fluoride supplements? ☐ Yes ☐ No

Fluoride rinses? ☐ Yes ☐ No

G. Does your child have a history of the following:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Blood Transfusion or Blood Products	☐	☐	Hepatitis	☐	☐
Heart Disease/Heart Murmur	☐	☐	Tuberculosis	☐	☐	Diabetes	☐	☐
Liver Disease	☐	☐	Sickle Cell Disease or Trait	☐	☐	Epilepsy or Seizure Disorder	☐	☐
Respiratory Disease (Asthma)	☐	☐	Blood Disorder or Anemia	☐	☐	Birth Defects	☐	☐
Brain Damage/Mental Retardation	☐	☐	Cancer	☐	☐	Other _____	☐	☐

H. Are there any other significant events or concerns regarding this child's medical or dental history? ☐ Yes ☐ No

Has your child any history of thumbsucking, fingersucking, lip biting, nail biting, pacifier? ☐ Yes ☐ No

Has your child had any unfavorable experience in a dental or medical office? ☐ Yes ☐ No

If yes to any list details _____

What are your primary concerns about your child's teeth? _____

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/ANY ALL NECESSARY DENTAL SERVICE CAN BE RENDERED. AUTHORIZATION IS HEREBY GRANTED FOR DR. SULLIVAN TO PROVIDE DENTAL CARE FOR THIS CHILD. FURTHERMORE, I ACKNOWLEDGE RECEIPT OF THE OFFICE POLICY AS TO CHARGES AND PAYMENTS AND AGREE TO COMPLY. I WILL BE FINANCIALLY RESPONSIBLE FOR THE CHANGES INCURRED FOR THE DENTAL TREATMENT OF THIS CHILD. I AUTHORIZE AND CONSENT TO USE OF VISUAL IMAGES FOR PROMOTIONAL AND EDUCATIONAL PURPOSES WITHOUT COMPENSATION.

Date _____ Signature _____

Parent or guardian