

THE CHILDREN'S DENTAL CLINIC
 801 Conestoga Road
 Berwyn, PA 19312-1295
 610-240-1213

To Parent/Guardian:

The information requested on this form is needed by **The Dental Clinic** to consider dental treatment for your child. Please complete and return as soon as possible.

Is your child covered by dental insurance? NO YES Name of Ins. Co.: _____

Has your child previously been treated at the Children's Dental Clinic? NO YES Year treated _____

SCHOOL NAME: _____ GRADE: _____

CHILD'S NAME: _____ Please indicate M or F

ADDRESS: _____

HOME PHONE: _____ CELL: _____ BIRTHDATE: _____

E-MAIL: _____ TODAY'S DATE: _____

Answers to the following questions are for our records only and are considered 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

I give permission to have my child _____ transported to **The Dental Clinic**
(please print name)

at T/E Middle School. My child may be referred to a local dentist who volunteers his/her services if extensive or special work is needed. I give my permission for my child to be treated by such a dentist and transported there. **I understand that the charge for each visit is \$5.00. I agree to make payment promptly and will let The Dental Clinic know if it becomes impossible for me to pay.** (Checks can be mailed directly to **The Children's Dental Clinic, 801 Conestoga Road, Berwyn, PA 19312.**)

PARENT/GUARDIAN SIGNATURE: _____

Please print name: _____