



Welcome



Dr.s Keaty & Brumbaugh
 Pediatric Dentistry
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 E-mail drkeatydds@yahoo.com
 Todays Date_____

ABOUT YOUR CHILD

CHILDS NAME_____ NICKNAME_____ SEX_____

HOME ADDRESS_____ ZIP_____

DATE OF BIRTH_____ AGE_____ HOME # ()_____ SS#_____

SCHOOL OR DAYCARE_____ GRADE_____ IS CHILD ADOPTED_____

IF YES, AT WHAT AGE_____ DOES THE CHILD KNOW? Y / N NAMES AND AGES OF BROTHERS AND SISTERS_____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN A PATIENT OF THIS OFFICE BEFORE? Y / N IF YES, NAMES AND AGES_____

FATHERS NAME_____

(ADDRESS IF DIFFERENT FROM CHILD)_____

HOME#_____ CELL#_____

EMPLOYER_____

WK PHONE #_____

MOTHERS NAME_____

(ADDRESS IF DIFFERENT FROM CHILD)_____

HOME #_____ CELL#_____

EMPLOYER_____

WK PHONE#_____

IS CHILD COVERED BY DENTAL INSURANCE? Y / N INSURANCE CO:_____

NAME AND SS# OF PERSON INSURED_____

Employer_____ Policy# _____ Group#_____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT? (NAME ,PHONE & ADDRESS)_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

PLEASE CIRCLE HOW YOU WOULD LIKE YOUR APPOINTMENT TO BE CONFIRMED PHONE E-MAIL BOTH E-MAIL ADDRESS_____ PHONE # TO CONTACT_____

MEDICAL - DENTAL HISTORY

CHILDS GENERAL HEALTH_____ APPROX. WEIGHT_____

CHILD'S PHYSICIAN_____ ADDRESS_____ PHONE_____

LAST VISIT DATE_____ REASON_____

IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING, PLEASE CIRCLE AND EXPLAIN BELOW.

- | | | | | |
|--------------------|---------------------|------------------------|-----------------------------|-------------------|
| 1. HEART TROUBLE | 7. CANCER | 13. EPILEPSY | 19. BLEEDING DISORDERS | 25. JAUNDICE |
| 2. RHEUMATIC FEVER | 8. LUNG PROBLEMS | 14. HEPATITIS | 20. SORE THROATS, EAR ACHES | 26. PREMATURE |
| 3. HIV POSITIVE | 9. MUMPS | 15. AIDS | 21. CIRCULATORY PROBLEMS | 27. HOSPITALIZED? |
| 4. UNCONSCIOUSNESS | 10. CONVULSIONS | 16. ASTHMA | 22. BLOOD TRANSFUSIONS | WHEN? |
| 5. BRAIN INJURY | 11. TEMPER TANTRUMS | 17. LIVER DISEASE | 23. CEREBRAL PALSY | WHY? |
| 6. DIABTES | 12. SEIZURES | 18. SICKLE-CELL ANEMIA | 24. MUSCULAR DYSTROPHY | 28. OTHER_____ |
- _____
- _____
- _____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

PURPOSE OF TODAY'S VISIT _____
ANY PARTICULAR DENTAL PROBLEM YOU WOULD LIKE TO DISCUSS WITH DR. KEATY AT THIS TIME?

LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING _____

CIRCLE ANY OF THE FOLLOWING YOUR CHILD IS ALLERGIC TO: 1. LOCAL ANESTHETIC

2. PENICILLIN 3. CODINE 4. TYLENOL 5. PHENEGRAN 6. LATEX/RUBBER PRODUCTS

7. OTHER _____

GIVE DATE AND DESCRIBE THE REACTION TO ANY OF THE ABOVE MENTIONED DRUGS:

HAS YOUR CHILD EVER HAD SURGERY? YES ___ NO ___ IF YES, GIVE REASON, DATE, AND NAME OF SURGEON

HAS CHILD EVER HAD HEARING, SIGHT, SPEECH, COORDINATION OR SPECIAL SCHOOLING PROBLEMS Y ___ N ___

IF YES, EXPLAIN _____

DO YOU FEEL YOUR CHILD'S SPEECH IS NORMAL FOR HIS/HER AGE? YES ___ NO ___ HAS CHILD EVER RECEIVED
INJURIES TO THE MOUTH? _____ TEETH _____ HEAD _____ IF YES, DESCRIBE AND GIVE DATE _____

WHO IS YOUR FAMILY DENTIST? _____ APPROX DATE OF YOUR LAST VISIT _____

HAS THIS CHILD BEEN TREATED OR EXAMINED BY ANOTHER DENTIST YES ___ NO ___ IF YES, GIVE NAME AND
DATE OF VISIT _____ WAS THE VISIT A FAVORABLE ONE YES ___ NO ___

IF NO, PLEASE EXPLAIN _____

HAS YOUR CHILD HAD A TOOTHACHE RECENTLY? YES ___ NO ___ IF YES, LOCATION: UPPER LEFT ___ LOWER LEFT ___
UPPER RIGHT ___ LOWER RIGHT ___ UPPER FRONT ___ LOWER FRONT ___, WHEN DOES IT HURT?

IS CHILD IN PAIN NOW? YES ___ NO ___ CIRCLE AND GIVE DATES FOR ANY OF THESE HABITS YOUR CHILD HAS
HAD OR HAS:

	DATE STARTED	DATE STOPPED
THUMBSUCKING	_____	_____
MOUTHBREATHING	_____	_____
PACIFIER	_____	_____
NURSING BOTTLE	_____	_____

INDICATE IF YOUR CHILD IS TAKING FLUORIDE IN ANY OF THE FOLLOWING FORMS:

LIQUID RINSE ___ PILLS ___ DROPS ___ WATER ___ VITAMINS ___ TOOTHPASTE ___ OTHER _____

PLEASE USE THIS SPACE TO MAKE US AWARE OF ANYTHING THAT WOULD HELP US UNDERSTAND AND TREAT
YOUR CHILD _____

I hereby authorize Dr. William A. Keaty and his staff to perform any and all routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I agree to the use of anesthetics and pre-medications considered Necessary or advisable by the dentist for the comfort and well-being of my child. Furthermore, I intend to pay all charges incurred at this office for dental service. I realize that fees for services are due at the time of the services unless other arrangements have been made.

PARENT OR LEGAL GUARDIAN _____ DATE _____

signature