Mark R. Byladek, DMD | 609.397.8833

RiverValleyDental

welcome

We are pleased to welcome your family to our practice. Please take a few minutes to complete this form, and if you have any questions we'll be glad to help you. We look forward to caring for you and your family!

CHILD INFORMATION

Child's Full Name		*Nickname*	*Sex:* ☐ *M* ☐ *F*
Date of Birth	*Age*	*Social Security #*	*Phone #*
Address		*City, State, ZIP*	
Grade	*School*	*City*	
Please list your child's hobbies/interest:			
Whom may we thank for referring you?			

PARENT/LEGAL GUARDIAN INFO

Parent's Marital Status: ☐ *Married* ☐ *Divorced* ☐ *Separated* ☐ *Widowed* ☐ *Single*

☐ MOTHER ☐ STEP-MOTHER ☐ GUARDIAN

Name			
Date of Birth	*Social Security #*		
Address		*City, State, ZIP*	
Home Phone #		*Work Phone #*	
Cell/Mobile/Pager/Other Phone #			
Dental Insurance? ☐ *YES* ☐ *NO*	*Subscriber Name*	*Subscriber Employer*	
Subscriber ID	*Subscriber Group #*		

☐ FATHER ☐ STEP-FATHER ☐ GUARDIAN

Name			
Date of Birth	*Social Security #*		
Address		*City, State, ZIP*	
Home Phone #		*Work Phone #*	
Cell/Mobile/Pager/Other Phone #			
Dental Insurance? ☐ *YES* ☐ *NO*	*Subscriber Name*	*Subscriber Employer*	
Subscriber ID	*Subscriber Group #*		

EMERGENCY CONTACT

Name		*Relation*
Work Phone#	*Home Phone #*	*Cell Phone #*

MEDICAL HISTORY

Child's Physician

Phone # | *Date of last visit*

Address | *City, State, ZIP*

Is your child currently under the care of the physician? If yes, please explain: ☐ *YES* ☐ *NO*

Please describe your child's current physical health: ☐ *Good* ☐ *Fair* ☐ *Poor*

Please list of medications that your child is currently taking.

Please list all medications/food/other that cause your child allergic reactions:

Has your child been diagnosed with or treated for any of the following?

☐ *Abnormal Bleeding*	☐ *Cancer*	☐ *Hearing/Speech*	☐ *Liver Problems*
☐ *ADD/ADHD*	☐ *Cerebral Palsy*	☐ *Heart Disease*	☐ *Psychiatric Problems*
☐ *AIDS/HIV+*	☐ *Cleft Palate/Lip*	☐ *Heart Murmur*	☐ *Rheumatic Fever*
☐ *Anemia*	☐ *Diabetes*	☐ *Hemophilia Type* _____	☐ *Sickle Cell Anemia*
☐ *Any Hospital Stays/Surgeries*	☐ *Ear Aches*	☐ *Hepatitis Type* _____	☐ *Tuberculosis (TB)*
☐ *Asthma*	☐ *Epilepsy/Seizures*	☐ *High/Low Blood Pressure*	
☐ *Autism Disorder*	☐ *GI Problems*	☐ *Hives*	
☐ *Blood Transfusion*	☐ *Handicaps/Disabilities*	☐ *Kidney Problems*	

Please discuss the above and any other medical problems your child has/had:

Do you consider your child to be: ☐ *Progressing normally in the learning process* ☐ *Slow in the learning process*

DENTAL HISTORY

*What is the **primary** reason for today's visit?*

Is your child currently having problems with any of the following?

☐ *Cavities*	☐ *Toothache*	☐ *Sensitive Teeth*	☐ *Trauma*
☐ *Gum Infection*	☐ *Color of Teeth*	☐ *Tooth Alignment*	☐ *Other*_____

Has your child experienced problems with previous dental work? If so, please explain: ☐ *YES* ☐ *NO*

Has your child had orthodontic treatment? ☐ *YES* ☐ *NO*

Is your child's home water supply fluoridated? ☐ *YES* ☐ *NO*

Does your child brush his/her teeth daily with flouride toothpaste? ☐ *YES* ☐ *NO*

Do you give your child any other form of flouride? If yes, describe: ☐ *YES* ☐ *NO*

Does your child floss his/her teeth daily? ☐ *YES* ☐ *NO*

Was your child bottle/breast fed? ☐ *YES* ☐ *NO* *If yes, what age was it completely stopped?*

Did your child suck their thumb? ☐ *YES* ☐ *NO* *If yes, what age was it completely stopped?*

Previous/Present Dentist | *Phone #* | *Date of last visit:*

SIGNATURE

Signature | *Relationship to Child* | *Date*