



# Child Information

Child's Name:  Nickname:

Date of Birth:  Age:  Sex:  Male  Female

Child resides with:  Mother  Father  Both Legal Guardian:

Parent's Marital Status:  Married  Single  Divorced  Widowed Relationship to Child

Child's Home Address:

Home Phone:  Child's Interests:

Grade and School:

Person Responsible for Child's Account:  E-mail:

Address of Person Responsible for Account:

If different than Child's Address

Father:  SSN:

Father's Birth Date:  Father's Cell Phone:

Mother:  SSN:

Mother's Birth Date:  Mother's Cell Phone:

Father's Employer:  Occupation:

Business Phone:

Mother's Employer:  Occupation:

Business Phone:

Name of Dental Insurance Company, if any:

Name of Insured:  Insurance ID#:

Insurance Company Phone and Address:

Other Children in Family (Please list names and ages):

Child's Physician:  Former Dentist:

Preferred confirmation methods:  E-mail  Phone  Text

Whom may we thank for referring you to our office?



# Child's Health History

Child's Name:

Has your child had any history of:

- Heart Trouble
- Allergies
- Diabetes
- Asthma
- Kidney or Liver Issues
- Seizures or Convulsions
- Bleeding Disorder
- Brain Injury
- Emotional, Nervous or Learning Disorder
- Other

**Check One**  
Yes No

Has your child ever been in the hospital overnight, or had any type of operation?

If yes, please explain:

Is there anything concerning your child's medical history which you feel may be important?

Does your child have allergies? (Medicine or Food)

Has your child experienced any unfavorable reaction from previous dental or medical care?

Does your drinking water contain fluoride?

Does your child have any of the following habits?

- Finger/Thumb Sucking
- Pacifier
- Mouth Breathing
- Teeth Grinding

Does your child snore? If yes, is it nightly?

Does your child brush daily?

- AM
- PM
- After Meals
- Supervised

Do you have concerns about your child's bite or the position of his/her teeth?

Is your child currently under medical care?

Is your child taking medication? Please list:

Has your child experienced any unfavorable reaction from previous dental or medical care?

I hereby authorize and direct the Doctors of Ahoyt Family Dental, P.C., assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) dental services that in their judgment are advisable with the exception of:

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown or extracted tooth, injury to the tongue, lips or cheek, damage to and the possible loss of existing teeth and or fillings, injury to nerves near the treatment site and fracture to a tooth which may need additional treatment. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I understand that I am free to withdraw my consent to treatment at any time, and this consent will remain in effect until such time that I choose to terminate it. If there is ever a change in my child's health, I will inform the doctor at the next appointment.