Pediatric Dentistry

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Patient Information

Name cl						Date			
	hild wo	ould like to b	e called						
Birthda	У	Ag	e Se	x					
		str	reet			town		zip code	
Your na	me			Relation	ship to child				
			reviously seen in						
			·						
					Date of Birth				
			nt than child's)_						
Mother's Employer						Phone ()		
Home Pl	hone (, <u> </u>		Ce	ell Phone ()	•		
Home A	ddress	s (if differe	nt than child's)_						
		-)	
			patient?						
Person r	espon	sible for ma	king appointmen	 ts					
Emerge	ncy co	ntact (name	/phone, other th	an self and/or	Spouse				
			eferring you to						
	•		ur child's dental						
Wilai is	ine i	eason for yo	di cilias delitai	VISIT F					
				Health	1 History				
Yes	No	Is your chi	ld in good health?						
		·	_	Do	ate of last ph	nysical exam			
Yes	No	Has your c	hild ever had a he	.calth problem?	ate of last ph	nysical exam			
	No	Has your cl	hild ever had a he hild ever been ho:	Do alth problem?_ spitalized or ho	ate of last ph ad any signifi	nysical exam	? Please		
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Do you consider your child to be

advanced in the learning process progressing normally slow in the learning process

				9 р. оосоо						
Was y	our chil	d breast-fed bot	tle-fed At what	age was it stopped?						
		d use a sippy-cup?								
		e does your child usually drink								
V	N 1-	11.4	Dental History	<u>-</u>						
Yes	IN0	Has your child ever been to t	ne dentist? Name (of dentist and date						
Yes	care?	Has your child experienced any unfavorable reaction from previous dental Explain								
Yes	No	Does your child suck a finger	, thumb or pacifier?)						
Yes	No	Does your child have pain wit	h chewing, yawning,	or wide opening?						
Yes	No	Does your child's jaw make no	oise and is pain asso	ciated with the sounds?						
Please	check i	your child is having problems	with any of the fall	lowina:						
Cavi			thache	Teeth Sens	itive					
	Trauma Gum Infections			Color of tee						
	rthodontics Jaw Sounds		· · · · ·	Other	••••					
Comments:										
			"Y	Office Use Only FI- City Water						
Yes	No	Is your home water supply flu	uoridated?		Pvt. Well					
Yes	No	Does your child use a fluoride			Public Well					
Yes	No	Do you give your child any oth	•	e? What?	ppm					
Yes	No	Does your child participate in		H₂O test kit qiven						
		Com								
			isent for Dental Ti signed by parent oi							
		(11,00 / 20	orginal by par ann or	rogar gaar arany						
taking probled I under unders childred instructure atm	of dent m. I wil rstand t tand th en learn nents, a nent and	authorize Dr. Kim to examine of all x-rays as may be considered allow photographs to be take hat dental treatment for child treatment in terms approprieto cooperate during treatment and using variable voice tone. It is fees incurred on the accordance of the second contract of the accordance in the accordance of the accordance in the accordance of the a	I necessary by Dr. K n of my child or chil dren includes effort ate for their age. D by using praise, ex will be responsible unt.	tim to diagnose and/or to diagnostic Id's teeth for diagnostic Its to guide their behavion In Kim will provide an en planation and demonstro for any charges incurre	reat my child's dental cor educational purposes. or by helping them to nvironment likely to help ation of procedures and ed on this child for dental					
Signat	ure		Date							
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