maple street dental group

TODAY'S DATE:

CHILD'S LAST NAME:	FIRST NAME:	INITIAL:
NICKNAME:	GENDER: M F	
BIRTHDAY:	SOCIAL SECURITY:	
HOME ADDRESS:	CITY:	STATE:
ZIP CODE:		
SCHOOL:	GRADE:	

PARENT'S INFO:

LAST NAME:	FIRST NAME:	INITIAL:
BIRTHDATE:	SOCIAL SECURITY:	
HOME ADDRESS:		
CITY:	STATE:	ZIP:
BEST PHONE NUMBER:	EMAIL ADDRESS:	

WHO IS ACCOMPANYING THE CHILD TODAY?

SAME AS ABOVE? YES NO
(IF YES, SKIP TO NEXT PAGE)

LAST NAME:	FIRST NAME:	INITIAL:
RELATION:	LEGAL GUARDIAN OF THIS CHILD? YES NO	

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WHO MAY WE THANK FOR REFERRING YOU?

ANY RELATIVES SEEN BY US:

REASON FOR TODAY'S VISIT:

IS THE CHILD'S WATER FLUORIDATED? YES NO

DOES THE CHILD BRUSH HIS/HER TEETH DAILY? YES NO

FLOSS HIS/HER TEETH DAILY? YES NO

PREVIOUS DENTIST:	DATE OF LAST VISIT:

WHY DID YOU LEAVE YOUR PREVIOUS DENTIST?

CHILD'S PHYSICIAN:	PHONE NUMBER:
DATE OF LAST VISIT:	IMMUNIZATIONS CURRENT? YES NO

CHILD'S CURRENT PHYSICAL HEALTH: GOOD FAIR POOR

DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

	BREAST FED		MOUTH BREATHER		THUMB/FINGER SUCKING
	CHEWING ON OBJECTS		NAIL BITING		TONGUE/CHEEK BITING
	CLENCHING/ GRINDING		NURSING BOTTLE HABITS		TONGUE THRUST
	SPEECH PROBLEMS		USED PACIFIER		LIP SUCKING/BITING

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HAS THE CHILD HAD/EXPERIENCED ANY OF THE FOLLOWING?

	ABNORMAL BLEEDING		DIABETES		LOW BLOOD PRESSURE
	AIDS/HIV		EPILEPSY		LUPUS
	ALLERGIES		MEASLES		HANDICAPS/DISABILITIES
	ANEMIA		HEARING IMPAIRED		MITRAL VALVE PROLAPSE
	ANY HOSPITAL STAYS		HEART MURMUR		MONONUCLEOSIS
	ASTHMA		HEMOPHILIA		RHEUMATIC FEVER
	BLOOD TRANSFUSION		HEPATITIS		SCARLET FEVER
	CANCER		HYPERTENSION		SICKLE CELL ANEMIA
	CHICKEN POX		HIVES		SKIN RASH
	CONGENITAL HEART DEFECT		KIDNEY PROBLEMS		TONSILITIS
	CONVULSIONS		LIVER PROBLEMS		TUBERCULOSIS (TB)

PLEASE DISCUSS ANY OTHER SERIOUS MEDICAL PROBLEMS:

PLEASE LIST ALL DRUGS THAT THE CHILD IS CURRENTLY TAKING;

IS THE CHILD ALLERGIC TO ANY OF THE FOLLOWING?

	ASPIRIN		ERYTHROMYCIN		METALS
	CODEINE		JEWELRY		PENICILLIN
	DENTAL ANESTHETICS		LATEX		TETRACYCLINE

ANY OTHER ALLERGIES? PLEASE LIST:

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I consent to my child having the following done: X-rays, Exam, Prophylaxis (cleaning).
INITIAL HERE:

I understand that holding my mouth open during treatment may temporarily leave my child's jaw feeling stiff and sore and may make it difficult to open wide for several days. I must notify your office if this or other concerns arise. I understand that if the recommended treatment is not performed, tooth or gum damage may progress causing me to lose one or more teeth. My child may also experience symptoms that may be damaging to overall health and which may increase in severity, and the cosmetic appearance of the teeth may deteriorate. I understand that every reasonable effort will be made to ensure the success of treatment. I understand that each person and situation is unique, and no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve my child's condition(s). INITIAL HERE:

I understand that antibiotics, anesthetics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore it is critical that I tell my dentist of all medications my child is currently taking, which I have done. INITIAL HERE:

I understand that loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections for local anesthesia is possible with any procedure. Rarely, temporary or permanent nerve injury and loss of feeling may result from an injection. INITIAL HERE:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. INITIAL HERE:

OFFICE USE ONLY

Confirmation of review of medical / dental information above with the patient named herein, and attestation of discussion of the risks, benefits, consequences, and alternatives of proposed treatment. Patient will be given the opportunity to ask questions, and I will ensure the patient understands what has been explained.

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DR. MATTHEW WEGRZYN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, , HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE

OF PRIVACY PRACTICES.

SIGNATURE:

DATE:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

	Individual refused to sign
	Communications barriers prohibited obtaining the acknowledgement.
	An emergency situation prevented us from obtaining acknowledgement.
	Other (to be documented in chart notes)