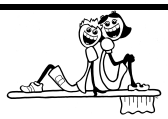
MADISON PEDIATRIC DENTISTRY PA
SPENCER MAUSETH, D.D.S.



Child's Name_____Nickname_____
First Middle Last
Sex: M ____ F ____ Birth date _____Age ____ Reason for this visit?_____
Is this your child's first dental visit? _____ Date of last visit _____Previous Dentist_____
Your child's attitude toward previous dental care?_____
Have we seen other children in your family? _____ Names _____
Is your child adopted? _____ Who has legal guardianship of your child?_____
How did you hear about our office?_____

MEDICAL INFORMATION

Is your child under doctor's care now? ____ For what reason? _____ Dr.'s Name _____
Is your child taking any medication? _____ What kind? _____ Reason _____
Has your child ever been hospitalized? _____ When? _____ Reason _____
Has your child had a history or difficulty with any of the following:

Yes	No		Yes	No		Yes	No	
___	___	Allergies (Medications)	___	___	Asthma/Breathing Problems	___	___	Arthritis
___	___	Autism	___	___	Anemia/Bleeding	___	___	Bones
___	___	Cancer/Tumors	___	___	Cerebral Palsy	___	___	Cleft Lip/Palate
___	___	Developmental	___	___	Diabetes	___	___	Eyes, Ears, Nose, Throat
___	___	Hearing	___	___	Heart	___	___	Kidney/Liver
___	___	Hepatitis	___	___	Immune Deficiency	___	___	Liver Previous
___	___	General Anesthesia/Surgery	___	___	Seizures/Epilepsy/Convulsions	___	___	Stomach/Intestinal
___	___	Syndromes	___	___	Other			

Comments / details _____
Does your child have any emotional or school problems? _____
Allergies or Medications_____

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ Or breast fed? _____ Until what age? _____
Does your child have any mouth habits, such as : finger/thumb sucking ___ pacifier ___ other _____
Has your child ever had any injuries to his teeth, mouth or head? ____ when? _____ details _____
Does your child brush regularly? _____ Does an adult assist with brushing? _____
Does your child floss? _____ Does an adult assist in flossing? _____
Has either parent or child been treated orthodontically? _____ Name of Orthodontist?_____
How would you expect your child to behave in our office? _____
Describe your child: Outgoing ____ Shy ____ Stubborn ____ Anxious ____ Frightened ____ Regular child _____
How may we help to make this visit a positive experience for your child?_____

The signature of a Legal Guardian below authorizes the completion of all agreed-upon necessary dental services.

SIGNATURE_____ **RELATIONSHIP TO CHILD** _____
DATE _____