

PEDIATRIC ACQUAINTANCE RECORD

Welcome. In order for us to better understand your child, please complete this form.

Extra room is provided at the end if you need more space to answer any items.

If you have any questions, please ask them. Thank You!

PERSONAL HISTORY

Child's Full name _____ Nickname _____ Sex M F
Date of Birth _____ Age _____ Weight _____ Birthplace _____ Race _____
Home Address _____ Home Phone _____ E-mail _____
By whom were you referred? _____ Patients here? Y N
Pediatrician's Name _____ Address/Phone _____
Mother's Name _____ Employer _____ Daytime Phone/Cell _____
Father's Name _____ Employer _____ Daytime Phone/Cell _____
Primary Dental Insurance: Subscriber's Name _____ Employer _____
SS # _____ Date of Birth _____ Insurance Co. Name _____
Secondary Dental Insurance: Subscriber's Name _____ Employer _____
SS # _____ Date of Birth _____ Insurance Co. Name _____

SOCIAL HISTORY

Child's favorites (i.e. pet, toy, color, hobby, etc.) _____
Names and ages of patient's siblings _____ Are they Patients here? Y N
Child's first language _____ Other languages spoken _____
Parents are (please circle): single married separated divorced remarried deceased
With whom does the child live? _____ Was the child adopted? _____
I consider my child to be: _____ advanced in learning _____ progressing normally _____ slow learner
My child has problems with: _____ speech _____ hearing _____ vision _____ sleep _____ other _____ no problems

DENTAL HISTORY

Has your child been to a dentist before? Y N Dentist's Name _____ Pediatric specialist? Y N
When was your child's last visit to a dentist? _____ Please describe: _____
Please describe how you think your child will behave today _____
Has your child had x-rays before? Y N If "yes," when? _____ Copies Requested? Y N
Oral habits (Please Circle): None Finger or Thumbsucking Pacifier Tongue Thrust Nail Biting Other
If habits have stopped, at what age? _____ Additional details of any oral habits: _____
Current fluoride prescription? Y N Do you use well water or bottled? Y N Water Filtration? Y N
How often does your child brush? _____ With help? Y N How often does your child floss? _____
My child was (check one): _____ bottle fed _____ breast fed If stopped, at what age? _____
I am concerned about: _____

MEDICAL HISTORY

Please give details to any items that you mark "yes" in the space provided at bottom

Is your child in good general health? Y N Is your child taking medication now? Y N If yes please describe _____

Has your child had or does he/she now have:

Allergies	Y	N	Mumps, measles, chickenpox	Y	N	High or low blood pressure	Y	N
Facial injuries	Y	N	Child's immunizations up to date	Y	N	Blood diseases or Anemia	Y	N
Toothaches	Y	N	Nervous or mental disorders	Y	N	Convulsions or Seizures	Y	N
Cleft lip or palate	Y	N	Frequent diarrhea or vomiting	Y	N	Reaction to any medicine	Y	N
Problems at birth	Y	N	Heart trouble or heart murmur	Y	N	Hospitalization or Surgery	Y	N
Kidney disease	Y	N	Scarlet fever or other high fever	Y	N	Steroid or Radiation Therapy	Y	N
Diabetes	Y	N	Rheumatic heart disease or fever	Y	N	Venereal Disease or Herpes	Y	N
Liver trouble	Y	N	Ear, eye, nose or throat trouble	Y	N	AIDS or HIV	Y	N
Stomach problems	Y	N	Tumors growths or cysts	Y	N	Breathing Problems	Y	N
Jaundice or Hepatitis	Y	N	Arthritis or Rheumatism	Y	N	Blood Transfusions	Y	N

FOR FEMALES ONLY:

Age of first menstrual period _____ Taking birth control pills? Y N Could child be pregnant? Y N

This space provided for details of any "yes" responses made above

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I acknowledge that I have completed the other side of this form to the best of my ability and that it is my responsibility to notify Dr.Ehrlich of any changes in the stated conditions. I also give permission to exchange information with my child's other health care providers as needed. I agree to diagnostic procedures and dental treatment as found necessary and desirable by Dr.Ehrlich, his associates or staff for the patient named on reverse. I have read and understand the financial policies of this office and agree to comply with them. I understand that I am financially responsible for all charges regardless of insurance. I have received a copy of this office's Notice of Privacy Practices.

X _____ Relationship to Patient _____ Date _____

PLEASE STOP HERE

Dentist's Summary of History and Notation of Significant Findings

FIRST MEDICAL HISTORY UPDATE

I have reviewed my child's medical history previously noted on this form. His/Her medical status and general health have changed as follows *(if no change, please write "NO CHANGE")*

Signature _____ Relationship _____ Date _____ Reviewer _____

PLEASE STOP HERE AFTER FIRST UPDATE

SECOND MEDICAL HISTORY UPDATE

I have reviewed my child's medical history previously noted on this form. His/Her medical status and general health have changed as follows *(if no change, please write "NO CHANGE")*

Signature _____ Relationship _____ Date _____ Reviewer _____

PLEASE STOP HERE AFTER SECOND UPDATE

THIRD MEDICAL HISTORY UPDATE

I have reviewed my child's medical history previously noted on this form. His/Her medical status and general health have changed as follows *(if no change, please write "NO CHANGE")*

Signature _____ Relationship _____ Date _____ Reviewer _____

PLEASE STOP HERE AFTER THIRD UPDATE

FOURTH MEDICAL HISTORY UPDATE

I have reviewed my child's medical history previously noted on this form. His/Her medical status and general health have changed as follows *(if no change, please write "NO CHANGE")*

Signature _____ Relationship _____ Date _____ Reviewer _____

PLEASE STOP HERE AFTER FOURTH UPDATE

FIFTH MEDICAL HISTORY UPDATE

I have reviewed my child's medical history previously noted on this form. His/Her medical status and general health have changed as follows *(if no change, please write "NO CHANGE")*

Signature _____ Relationship _____ Date _____ Reviewer _____