

Was your child nursed or slept with a bottle? ____ Y ____ N How long? _____
 Has your child any trauma to face or teeth? _____
 Does your child have a toothache now? _____
 Who may we thank for referring you to our office? _____
 Does your child have any of the following habits?
 Thumb sucking _____ Pacifier _____ Nail biting _____ Grinding _____
 Are there any questions or topics you would like Dr. Romasan to address at this time? _____



Child's Medical History

Name & Phone of PEDIATRICIAN _____
Date of last medical exam _____
 Is your child taking any medicine or vitamins at this time? Please list _____

 Has your child ever been hospitalized? _____ If yes, for what and how long? _____

 Please list any Behavioral or Developmental problems _____
 Is Child in good health? _____
 Is Child under the care of a physician? _____ For what? _____

Has the child ever had any of the following? Please circle those that apply:

- | | |
|---------------------------------|-------------------------------|
| Abnormal Heart condition/murmur | Asthma |
| Allergy to Penicillin | Allergies _____ |
| Bleeding Disorder | Hepatitis/Liver Disease |
| Diabetes | Eating Disorders |
| Stomach Problems | Epilepsy/Seizures |
| Tumors/Cancer Treatment | Kidney Disease |
| Exposure to AIDS/HIV | Exposure to Tuberculosis (TB) |
| Glandular/Hormone Disease | Mental /Nervous Disorder |
- Please give any other information the doctor should be aware of _____



Consent for Treatment

As the parent /guardian of _____ I hereby give my consent for Dr. Romasan to render dental services, anesthesia, and accepted behavior management techniques to and for the benefit of the patient that may be necessary to correct any oral deficiency, abnormality, infection or disease.

NO TREATMENT, ANESTHESIA OR X-RAYS WILL BE PERFORMED WITHOUT YOUR PRIOR KNOWLEDGE.

The parent/guardian acknowledges that he/she is responsible for all charges incurred in the rendering of dental services, regardless of what type of insurance he/she carries. This office will make every effort to assist you in filing and processing the claims.

SIGNATURE _____ DATE _____ Relationship to Patient _____