



DAVID E. DOYLE, D.D.S.

SUNNYSIDE DENTISTRY FOR CHILDREN PC
503-786-5080
10121 S.E. Sunnyside Rd., Suite 320
Clackamas, Oregon 97015

Child's Full Name : _____ Nick Name: _____ DOB: _____ Age: ____ M / F

Child's School: _____ Referred by: _____

Person responsible for account? _____ Who does child live with? _____

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Hm. #: _____ Wk. # _____ Hm. #: _____ Wk. #: _____

Cell #: _____ E-mail: _____ Cell #: _____ E-mail: _____

Employer: _____ Position: _____ Employer: _____ Position: _____

SS # _____ DOB: _____ SS# _____ DOB: _____

Marital Status: S M D sep Marital Status: S M D sep

Brothers / Sisters, list all:

Full Name _____ DOB: _____ Full Name _____ DOB: _____

Full Name _____ DOB: _____ Full Name _____ DOB: _____

MEDICAL HISTORY AND HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS. CIRCLE YES (Y) OR NO (N) WHERE INDICATED

1. Name and Address of Physician: _____ Phone: _____

2. Date of last physical exam: _____ Findings? _____

3. Does your child have any illnesses now? Y / N If yes, what? _____

4. Is your child presently under a physician's care? Y / N If yes, for what? _____

5. Has your child ever been hospitalized? Y / N If yes, why and when _____

6. Is your child currently taking any medications? Y / N If yes, please list medications

Medication: _____ Dosage: _____ why: _____

Medication: _____ Dosage: _____ why: _____

7. Does your child have a history of any allergies to medications? Y / N please list: _____

8. Does your child have a history of any allergies to foods, etc? Y / N please list: _____

9. Is your child current on immunizations? Y / N

10. Was your child born with any heart defects? Y / N If yes, was any surgery required? Y / N

11. Is premedication required for dental treatment? Y / N Who prescribes the medication? _____ Phone: _____

DOES YOUR CHILD HAVE ANY HISTORY OF:

- Aids.....Y / N Diabetes..... Y / N Jaundice..... Y / N
Anemia.....Y / N Digestive System Disorder..... Y / N Kidney Problems..... Y / N
Asthma.....Y / N Down Syndrome..... Y / N Learning Problems..... Y / N
Autism.....Y / N Emotional Problems..... Y / N Liver Disease..... Y / N
Autoimmune Disease.....Y / N Endocrine System Disorder..... Y / N Lung Disease..... Y / N
Bacterial or Viral Infection..... Y / N Epilepsy..... Y / N Mental Retardation..... Y / N
Behavior Problems..... Y / N Eye or Sight Problems..... Y / N Reccurent Headaches..... Y / N
Blood Disease..... Y / N Excessive Bleeding..... Y / N Rheumatic Fever..... Y / N
Blood Transfusions, date _____ Hearing Problems..... Y / N Speech Impediment..... Y / N
Breathing Problems..... Y / N Heart Trouble..... Y / N Temporal Mandibular Joint Problems.. Y / N
Congenital Birth Defects..... Y / N Hepatitis A, B, C..... Y / N Tuberculosis..... Y / N
Convulsions / Seizures..... Y / N HIV..... Y / N Tumors/Cancer..... Y / N

ARE THERE ANY MEDICAL OR PSYCHOLOGICAL ISSUES OR DISABILITIES NOT LISTED ABOVE THAT WE NEED TO KNOW? DESCRIBE : _____

DENTAL HISTORY

1. Is this your child's first dental visit? Y / N If no: Date of last dental visit and x-rays: _____
2. Is this an emergency visit? Y / N
3. What is your reason for bringing your child to the dentist? _____

4. Is there now or has there ever been any of the following?
cavities: Y / N broken teeth: Y / N gum infection: Y / N pain: Y / N
toothache: Y / N extracted teeth: Y / N mouth injury: Y / N
5. Does your child have a history of:
thumb sucking: Y / N teeth grinding: Y / N pacifier: Y / N
finger sucking: Y / N nail biting: Y / N
lip sucking: Y / N prolonged use of bottle and/or breastfeeding: Y / N
6. Has your child had an unfavorable medical or dental experience? Y / N
Please explain: _____
7. Has your child ever seen an orthodontist? Y / N Orthodontist's Name _____
Is your child currently under orthodontic care? Y / N Orthodontist's Name _____
8. Is your child's water fluoridated? Y / N
9. Does your child:
Brush regularly: Y / N Use toothpaste containing fluoride: Y / N
Use dental floss: Y / N Use fluoride rinse or supplements: Y / N

INFORMED CONSENT

THE PERMISSION OF PARENT OR GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR.

I give the doctors permission to use such measures as deemed necessary in their professional judgement to render the diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollens, dust, blood or body disease, gum or skin reaction, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

FINANCIAL ARRANGEMENTS:

Payment is requested at the time treatment is provided. We accept most dental plans and will submit claims for you if you have provided all required insurance information. If you have insurance, we collect the estimated portion or percentage not covered at each visit. In the event of insurance payment delay or disputed claim beyond 45 days, you will need to pay your account in full and arrange for reimbursement by your carrier. The ultimate responsibility for your account rests with you.

SIGNATURE: _____ relationship to child _____ date _____

REVIEWED BY DOCTOR _____ date _____

1. Any Health Updates: Y / N explain _____

Parent/Guardian signature _____ date _____

2. Any Health Updates: Y / N explain _____

Parent/Guardian signature _____ date _____

3. Any Health Updates: Y / N explain _____

Parent/Guardian signature _____ date _____

4. Any Health Updates: Y / N explain _____

Parent/Guardian signature _____ date _____

5. Any Health Updates: Y / N explain _____

Parent/Guardian signature _____ date _____