Tina P. Moses, DMD, PC

Pediatric Dentistry

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Please print all information clearly. Please include area code with all phone numbers.

Child's Biographical, Medical and Dental History

Last Name:		First:		Middle:	
SEX:	AGE:	BIRTH:	RACE:	GRADE:	SCHOOL:
Address:		City:		ST:	Zip:
Father:		Home ☎:		Cell:	
Mother:		Home ☎:		Cell:	
Do both parents live together? ☐ YES ☐ NO		(If not, with whom does the child live?)			
Father's occupations/employer:				Work ☎:	
Mother's occupation/employer:				Work ☎:	
Email:		Relative:		☎:	

Check any of the following conditions that your child presently has or previously had.

	AIDS		Convulsions		HIV-positive		Nose/throat disorder
	Anemia		Diabetes		Hormone disorder		Prolonged illness
	Asthma		Ear disorders		Hyperactivity		Rheumatic fever
	Bleeding tendency		Epilepsy		Jaundice		Skin disease
	Blood disease		Eye disorders		Kidney disease		Speech problem
	Blood transfusion		Fainting		Liver disease		Stomach problem
	Bone disorder		Heart condition		Lung disease		Other
	Brain disorder		Hemophilia		Mental retardation		
	Cancer		High blood pressure		Muscle disorder		

Child's Physician	Address	Phone

	No		Yes	Does your child have any other medical condition?
	No		Yes	Is your child taking any medicine?
	No		Yes	Is your child allergic to any medicine or food?
	No		Yes	Has your child ever been hospitalized?
	No		Yes	Is this your child's first visit to the dentist?
	No		Yes	Were there any problems with previous dental treatment?
	No		Yes	Is your child using fluoride tablets, drops, or rinses?
	No		Yes	Has your child had a toothache recently?
	No		Yes	Does your child suck a thumb, finger or have any other oral habit?
	No		Yes	Has your child ever injured his/her teeth or jaws?
	No		Yes	Does your child have a dental condition about which you are especially concerned?

How often are your child's teeth brushed?_____By whom?_____

What is the source of your child's drinking water? ☐ Public water ☐ Well water

I acknowledge that this information is correct and hereby authorize a dental examination for my child including necessary radiographs, photographs and acceptable methods to accomplish these services. I authorize the use of any radiographs, photographs and records for the purpose of teaching, research and scientific publication.

Parent or Guardian's Signature_____ Date_____