

KEITH GJEBRE, D.M.D.

Practice Limited to Pediatric Dentistry

Child's Name _____ Date of Birth _____ Wt. _____

Child's Address _____

School _____ Grade _____

Family Dentist _____ Referred By _____

Father (or Legal Guardian if Applicable)

Mother

Name _____

Name _____

Address _____

Address _____

Phone _____

Phone _____

Employer _____

Employer _____

Address _____

Address _____

Phone _____

Phone _____

Dental Ins. _____

Dental Ins. _____

Your D.O.B. _____

Your D.O.B. _____

S.S. # or Agreement # _____

S.S. # or Agreement # _____

Group # _____

Group # _____

MC/Visa # _____

MC/Visa # _____

Who has primary responsibility for this account? _____

Check here if interested in a no-interest payment plan that is available with approved credit.

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Child's Name _____ Nickname: _____

DENTAL

1. Is your child having any dental problems? _____ Explain _____

2. Has your child been to the dentist before? _____ Last visit? _____ Where? _____
3. Has your child had any dental injuries? _____ Explain _____

4. What habits does your child have which might affect the teeth or mouth?
 Mouth Breather Grinding teeth Finger Sucking thumb Pacifier
 Other _____
5. Does your child take Fluoride vitamins? _____ What kind? _____
Dose? _____ (.25, .5, 1.0)
6. Diet Summary _____
7. General Dental history of family. _____
8. Does your child brush his own teeth? _____ If not who does? _____
How often? _____
9. Did your child sleep with a bottle? _____ What did it contain? _____
When did he or she stop? _____

MEDICAL

1. Is your child in good health now? _____
2. Does your child have any allergies to food or drugs? _____
Specify _____ Warned against any drugs? _____
3. Are your child's immunizations up to date? _____
4. Is your child taking medication? _____ Specify _____
5. Were there any problems during pregnancy? _____ Explain _____

6. Ages of brothers and sisters? _____
7. Has your child been hospitalized? _____ When? _____
For What? _____ Where? _____
8. Has your child ever had any of the following?

<input type="checkbox"/> Cardiac/Heart disease or defects	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Cleft Lip/Palate
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Down's Syndrome
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Hepatitis/Liver disease	<input type="checkbox"/> Blindness
<input type="checkbox"/> AIDS	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Birth defects
<input type="checkbox"/> Asthma/Breathing difficulties	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Hemophilia/Bleeding disorders	<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Anemia	
9. Who is your child's pediatrician/physician? _____
10. Any additional information? _____

Signature _____ Date _____