

## Robert J. Moretta, D.D.S.

Thank you for choosing our office for your dental treatment. In order that we may be more effective in meeting your child's needs, please complete this entire form in full.

Patient's name _____	Nick name _____	Age _____
Date of Birth _____	Social Security Number _____	
Residence Address _____	City _____	Zip _____

Father's name _____	Residence Phone _____	
Residence Address _____	City _____	Zip _____
Mailing Address _____	City _____	Zip _____
Date of Birth _____	Social Security Number _____	
Driver's License Number _____		
Employed by _____	Occupation _____	
If self employed, name of business _____		
Business Address _____	City _____	Zip _____ Phone _____
Insurance company _____	Group Number _____	
Mother's name _____	Residence Phone _____	
Residence Address _____	City _____	Zip _____
Mailing Address _____	City _____	Zip _____
Date of Birth _____	Social Security Number _____	
Driver's License Number _____		
Employed by _____	Occupation _____	
If self employed, name of business _____		
Business Address _____	City _____	Zip _____ Phone _____
Insurance company _____	Group Number _____	
In case of emergency, whom may we notify, _____	Phone _____	
Relation _____	Address _____	
Name of Pediatrician _____	City _____	Phone _____
Former Dentist (if any) _____	City _____	Phone _____
Purpose of appointment _____		
Is this office visit for emergency dental care? _____		

**Please complete the other side**

## Medical History

1. Is your child under medical treatment now?.....yes no  
If so, what is the condition being treated? \_\_\_\_\_
2. Has your child ever had an serious illness or operation?.....yes no  
If so, what was the illness or operation? \_\_\_\_\_
3. Has your child ever been hospitalized?.....yes no  
If so, what was the problem? \_\_\_\_\_
4. Is your child taking any drugs or medications?.....yes no  
If so, what? \_\_\_\_\_ What dosage? \_\_\_\_\_
5. Is your child allergic or sensitive to any drugs or medications?.....yes no  
If so, what? \_\_\_\_\_

6. Does your child have or have they had any of the following? (Please check known conditions)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tumors/Growths             |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Epilepsy/Convulsions  | <input type="checkbox"/> Nervous Disorders          |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Dry Mouth                  |
| <input type="checkbox"/> Hepatitis/Jaundice         | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Difficulty with Swallowing |
| <input type="checkbox"/> Mitro Valve Prolapse (MVP) | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Kidney Disease             |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Excessive Bleeding         |
| <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Allergies/Hay Fever   | <input type="checkbox"/> Other _____                |

7. Does you child have any disease, condition or health problem not listed that we should know about? yes no  
If so, what? \_\_\_\_\_

## Dental History

1. Is this your child's first visit to a dentist?.....yes no
2. Has your child ever had local anesthetic (lidocaine, novocaine, etc)?.....yes no
3. Has your child ever had any unfavorable reaction from a local anesthetic?.....yes no
4. Has your child ever had any serious trouble associated with any previous dental treatment?.....yes no  
If so, explain. \_\_\_\_\_
5. How long since your child's last dental treatment? \_\_\_\_\_
6. How long since your child's last dental x-rays? \_\_\_\_\_
7. Are you satisfied with the appearance of your child's teeth?.....yes no  
If no, what would you like to be changed? \_\_\_\_\_
8. Does your child have an oral habit (thumb sucking, nail biting, etc.)?.....yes no  
If so, what is it? \_\_\_\_\_

## Consent

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever have changes in their health, or if their medicines change, I will inform the doctor. I authorize the doctor to take radiographs, study models or any other diagnostics aids deemed appropriate in order to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated after proper explanation, alternatives and consequences have been given to me.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_