Silas E. McAninch, DDS, PA

Pediatric and Adolescent Dentistry

2711 South Tamiami Trail, Sarasota, Florida 34239 • (941) 953-3535

THE FOLLOWING HISTORY IS NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL. Due to the need to have current medical information we will be asking you to update this medical information at each six month check-up. We thank you for your cooperation in this matter.

Patient's Name ______________________________

HEALTH HISTORY

	Yes	No
Is your child in good health?	______	______
Does your child have regular medical examinations?	______	______
Is your child up to date with immunizations?	______	______

Check any of the following that may pertain to your child:

______ Rheumatic fever	______ Bleeding disorder/anemia	______ Epilepsy	______ Mental disorder / Brain injury
______ Heart Condition	______ Cerebral palsy	______ Hepatitis	______ Malignancy/chemo/radiation tx.
______ Heart murmur	______ Liver disorder	______ Diabetes	______ Tuberculosis
______ Speech disorder	______ Kidney disorder	______ Prosthetic joint/valve	______ Sickle Cell Anemia
______ Hearing disorder	______ Asthma/ Allergies	______ Autism	______ HIV, immunosuppression
______ Vision disorder	______ High or low blood pressure		______ Other

Who is your child's physician? ______________________________ ______________________________

Is your child presently taking any medicine? ______________ What? ______________________________

Has your child ever experienced any unfavorable reaction to medicine (such as penicillin, aspirin, xylocaine)? ______________

Is there any reason to your knowledge why a local anesthetic cannot be used? ______________________________

Is your child presently undergoing medical treatment? ______________________________

If so, give the reason ______________________________

Has your child been hospitalized since birth? ______________________________

If so, Date: ______________________________ Reason ______________________________

Is this your child's 1st dental visit? ______________________________

Is your child a thumb/finger sucker? ______________________________ Use a pacifier? ______________

If your child was bottle fed, at what age was it discontinued? ______________________________

Has your child ever had an unfavorable experience in a dental office? ______________________________

If so, describe ______________________________

Do we have permission to request and/or send copies of your dental records including x-rays? ______________

Date of your child's last dental care ______________________________

Does your child have a toothache? ______________________________

Purpose of this appointment ______________________________

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment ______________

____

PAYMENT OF PROFESSIONAL FEES

I UNDERSTAND THAT PAYMENT IS DUE AT THE CONCLUSION OF EACH APPOINTMENT. THE PARENT BRINGING THE PATIENT TO OUR OFFICE IS RESPONSIBLE TO US FOR PAYMENT OF THE ACCOUNT. Delinquent accounts are handled by outside Collectors. Such accounts will be required to pay the balance due in full and to pay cash in advance before any new appointments will be honored.

PERMIT FOR DENTAL SERVICES UPON A MINOR

Thank you for choosing our office to serve your child's dental needs. Each child who comes to us is special, and we try hard to provide quality work and service. Also, we constantly seek new ways to serve you better. Please let us know if there is any way you think we can better serve you. It may not be possible to act upon every request, but all comments are respectfully appreciated and considered. If you like the care your child is receiving here, please tell your friends about us. We welcome new patients.

I, being the parent or legal guardian of the child named on this form, do hereby authorize and request the performance of dental services upon this patient, and do authorize emergency procedures that the judgement of the doctor may determine to be necessary during treatment.

______________________________ ______________________________

Date Signed (Parent or Guardian)

Please notice that information is requested on both the front and the back of this form. Please be sure that both sides are completed in full before returning this to the receptionist. Thank you.

______________________________ Dental Assistant reviewing history

FAMILY INFORMATION

Is this your child's first visit to our office? ____________________

Names of other children in the family ____________________

____

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Name **one** person to whom any correspondence about this account should be addressed (usually a parent) __________

Title (Mr., Mrs., Miss, Ms., Dr., Rev.) ____________________

Address ____________________

City ______________ State ______________ Zip Code ______________

Home Phone ______________ Work Phone ______________

E-Mail Address ______________ Cell Phone ______________

Employer ____________________

Employer's Address ____________________

Social Security Number ____________________

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Name a second person to whom any correspondence about this account may be addressed (usually the other parent)

Title (Mr., Mrs., Miss, Ms., Dr., Rev.) ____________________

Address ____________________

City ______________ State ______________ Zip Code ______________

Home Phone ______________ Work Phone ______________

Employer ____________________

Employer's Address ____________________

Social Security Number ____________________

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Child's Full Name ____________________
Last First Middle

Name called or Nickname ____________________

Address ____________________

City ______________ State ______________ Zip Code ______________

Birthdate ______________ Sex ______________

School Attending ____________________

Hobbies ____________________

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From whom did you hear about our Office? Please be specific by naming a person, or indicate any other way you heard about our Office such as choosing our name from the Yellow Pages. We like to thank everyone who refers patients to our practice. ____________________

Please turn this over and be sure the Medical History and Consent area on the other side are completed before returning this to the receptionist. Thank you very much.