Creative Smiles Dental Clinic

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Child's name ____________________ Nickname ____________________

Child's address____________________ City ____________ PC ____________

Phone number ____________________ AHC ____________________

Parent accompanying child ____________________ Sex ____________

DOB ____________ Is this your child's first dental visit? **Yes** **No**

Medical history

Has your child had any of the following medical problems? **Circle all that apply**

Asthma
Abnormal bleeding
Disabilities
Cancer
Epilepsy

Diabetes
Hearing Impaired
Heart condition
Hepatitis
HIV / AIDS

Tuberculosis

Any allergies to any medications? if so, what ? ____________________

Taking any medications? Including vitamins ____________________

Physician's name ____________________ Phone Number ____________________

Is there anything in the child's medical history we should be aware of?

____

How often does he/she brush?____________________

Thumb sucker? **Yes** **No** currently drinks from a bottle? **Yes** **No**

Signature of parent/guardian ____________________ **Date** ____________________