

Do you consider your child to be advanced in the learning process
 progressing normally
 slow in the learning process

Was your child breast fed bottle fed at what age was it stopped? _____

Dental History

Yes No Has your child ever been to the dentist? Date of last xrays (if taken) _____
Name of dentist and date _____

Yes No Has your child experienced any unfavorable reaction from previous dental care? Explain _____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of teeth |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Other |

Comments: _____

Fluoride History

Yes No Is your home water supply fluoridated?

Yes No Does your child use a fluoride toothpaste?

Yes No Do you give your child any other form of fluoride? What? _____

Yes No Does your child participate in a school fluoride rinse program?

<small>Office Use Only</small>
<input type="checkbox"/> Fl- City Water
<input type="checkbox"/> Pvt. Well
<input type="checkbox"/> Public Well _____ppm
<input type="checkbox"/> H ₂ O test kit given

Consent for Dental Treatment

I request and authorize Dr. Hsu to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Hsu to diagnose and/or treat my child's dental problem. **I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I grant permission to Dr. Hsu and staff to contact my child's physician to coordinate care as necessary.** I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Hsu will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ Date _____