Tina S. Merhoff, D.D.S.
Pediatric Dentistry
185 Kimel Park Drive * Winston Salem, NC 27103 * Telephone 336-659-9500 * Fax: 336-714-1017

Demographic Information

Patient _____ Date _____
First MI Last
Name Child would like to be called_____ Patient SS# _____
Birthday _____ Age _____ Sex _____ Home Phone _____
Home Address _____
Street Town Zip Code
Name and ages of other children in family _____
School Patient Attends _____ Grade _____

Mother _____ DOB _____ Email _____
Mother's Employer _____
Mother's Cell Phone_____ Mother's Work Phone _____
Father _____ DOB _____ Email _____
Father's Employer _____
Father's Cell Phone _____ Father's Work Phone _____
Who has legal custody of patient? _____
Dental Insurance? ___ Yes ____ No
Whom may we thank for referring you to us? _____
What is the reason for your child's dental visit? _____

Health History

__ Yes __ No Is your Child in good health? Name of child's physician _____
Date of last physical exam _____
Pharmacy Name:_____ Pharmacy Phone: _____
__ Yes __ No Has your child ever had a health problem? _____
__ Yes __ No Has your child ever been hospitalized? Please give reason and dates _____
_____
__ Yes __ No Is your child allergic to anything? _____
__ Yes __ No Is your child currently taking any medications? Please give medication and reason __
_____
__ Yes __ No Were there any problems at birth? _____

Please check if your child has been treated for any of the following:

_ Heart Disease	_ Bleeding/transfusions	_ Asthma	_ Blood Dyscrasias
_ Liver/ GI Disease	_ Anemia	_ Diabetes	_ AIDS
_ Kidney Disease	_ Rheumatic Fever	_ Hepatitis	_ Mental Delays
_ Speech/Hearing	_ Seizures	_ Cleft Lip/Palate	_ Physical Delays
_ Cerebral Palsy	_ Cong. Birth Defects	_ Personality/Social	_Other Problems
_ Cancer/Tumors	_ Recurrent Headaches	_ Frequent Infections	

Please elaborate on any items checked: _____
_____
_____
_____
_____

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? 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

__ Cavities	__ Toothache	__ Teeth Sensitive
__ Trauma	__ Gum Infections	__ Color of Teeth
__ Orthodontics	__ Jaw Sounds	__ Other

Comments: _____
_____

OFFICE USE ONLY
__Fl -City Water
__Pvt. Well
__Public Well _____ppm
__H_2O test kit given

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?

Consent for Dental Treatment

I request and authorize Dr. Merhoff 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. Merhoff 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 understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their ages. Dr. Merhoff 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.

By signing this document, I am confirming that I am a legal guardian for this child and understand that ultimately I will be financially responsible for this patient. However, I understand that the adult bringing this patient to his or her appointment will be responsible for their patient portion on the day that services are rendered.

Signature _____ Date_____