



# FORT WORTH PEDIATRIC DENTISTRY

BRUCE H. WEINER, D.D.S. • JANELL I. PLOCHECK, D.D.S.

DIPLOMATES OF THE AMERICAN BOARD OF PEDIATRIC DENTISTRY

NATHAN G. WEST, D.M.D

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Child's Pediatrician: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST US IN KEEPING YOUR CHILD'S MEDICAL HISTORY UP TO DATE:

Has your child seen his/her physician since the last visit? Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

Has your child's medical history changed since the last visit? Yes \_\_\_ No \_\_\_ If so, how? \_\_\_\_\_

Is your child taking any medications at the present time? Yes \_\_\_ No \_\_\_ If so, what and why? \_\_\_\_\_

Has your child been ill or run fever in the last 24 hours? Yes \_\_\_ No \_\_\_

Has your child received any injections or blood transfusions within the last year? Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

Any injury to head, neck or teeth in the last 6 months? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Any dental problems developed or developing? Yes \_\_\_ No \_\_\_

Other dental or medical concerns or problems? \_\_\_\_\_

IN ORDER TO CONTINUE TO PROVIDE THE BEST POSSIBLE CARE OF YOUR CHILDREN, WE WOULD APPRECIATE SUGGESTIONS:

Do you feel you and your child are well-treated in our office? Yes \_\_\_ No \_\_\_ If not, why not? \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

### FOR OFFICE USE ONLY:

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age - Years: \_\_\_\_\_ Months: \_\_\_\_\_ Last dental exam \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
				A	B	C	D	E	F	G	H	I	J			
DECAY/FILLED																
TX PLANNED																
TX PLANNED																
DECAY/FILLED																
				T	S	R	Q	P	O	N	M	L	K			
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

TREATMENT: PREMED / AM ONLY / NPO / HOP DR. P / DR. W / DR. N

O = PRESENT X = EXFOLIATED OR EXTRACTED BLUE = EXISTING RED = DECAY OR TREATMENT NEEDED