DENTISTRY JUST FOR KIDS

Eugene V. Nolfi, Jr., DDS, MS, P.A.

Pediatric Dentistry

We sincerely welcome you and your child into our practice and we will attempt to make your dental visits as pleasant as we can. In order for us to better understand your child please complete this form as thoroughly as possible. Thank you so very much!

1) Child's name:________________ Nickname:________________ ☐ male ☐ female
2) Date of birth:________________
3) Who's Mom or Dad's Dentist?________________ Patient's Physician:________________
4) Is patient homeschooled? ☐ Yes ☐ No
   If not, what school is patient attending?________________ Intercessions? ☐ Yes ☐ No
5) Names of brothers and sisters:________________
   (Circle the ones we have seen)
6) Who may we thank for referring you to our office?________________
   Their address if known:________________
7) What is your main concern on this visit?________________
   ____
8) Is your child in good health? ☐ Yes ☐ No
9) Does your child have special needs? ☐ Yes ☐ No If so, please list:________________
10) Has your child had any history of:

Epilepsy	☐ Yes	☐ No	Blood Disorders	☐ Yes	☐ No	Cerebral Palsy	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney or Liver Disorders	☐ Yes	☐ No

   Or any other medical condition for which they have received treatment or medicine? ☐ Yes ☐ No If so, please list:________________
   ____
11) Has your child ever been hospitalized? ☐ Yes ☐ No
   If so, please list:________________
   ____
12) Is your child currently taking any medicine? ☐ Yes ☐ No
   If so, please list:________________
13) Has your child had any unfavorable reaction or allergy to drugs or local anesthetics? ☐ Yes ☐ No
   If so, please describe:________________
14) Is your child allergic to latex? ☐ Yes ☐ No
15) Is your child currently sucking a thumb(s), finger(s), or using a pacifier? ☐ Yes ☐ No
   If so, for how long?________________
16) Is your child still feeding on the bottle or breast? ☐ Yes ☐ No
   If no, at what age did he stop?________________
17) Does your child have or had in the past frequent ear and throat infections? ☐ Yes ☐ No
18) Has your child any history of hearing loss or speech problems? ☐ Yes ☐ No
   If so, please explain:________________
   ____
19) Is your child adopted? ☐ Yes ☐ No
20) Has your child had a space maintainer, braces, orthodontic treatment or dental tooth movement? ☐ Yes ☐ No
   Please explain:________________
21) Has your child had any favorable or unfavorable experience in a dental or medical office? ☐ Yes ☐ No
   If so, in what way?________________
   ____
22) How does your child react to injury?________________
23) How does your child react around strangers?________________
   ____

Continue to Back