



**NORTH SUBURBAN
DENTAL ASSOCIATES**

Committed to Patient Satisfaction

4833 CHURCH STREET • SKOKIE, IL 60077
PHONE (847) 673-7118

For Office use only

Chart #: _____

Child's Name: _____ Today's Date: _____

Child's Physician: _____ Doctor's Phone #: _____

___ Yes ___ No Is your child in good health? Please list any health problems: _____

___ Yes ___ No Has your child ever been hospitalized? If so, please list why and dates: _____

___ Yes ___ No Is your child allergic to anything (i.e. medications, latex, food, etc.)? _____

___ Yes ___ No Were there any difficulties with your pregnancy or child's birth? _____

___ Yes ___ No Is your child taking any medications? Please list: _____

Please check if your child has been treated or had difficulty with any of the following conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Personality/Social Issues |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Physical Delays |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital Birth Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Speech/Hearing |
| | | <input type="checkbox"/> Other |

Please elaborate on ANY items marked: _____

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 kind? _____

Purpose of today's visit?

_____ First check-up

_____ Regular check-up, radiographs (if necessary) and cleaning.

_____ Emergency visit: Please describe the nature of the emergency: _____

_____ Referral from another dentist. Please describe the reason for the referral: _____

Do you anticipate your child will:

_____ Cooperate fully

_____ I am not sure how my child will react

_____ I do not expect my child to cooperate-please elaborate: _____