



8

DENTAL HISTORY

YES/NO Is your child having any dental pain?
YES/NO Is this your child's first dental visit? If not, previous dentist and date:
YES/NO Has your child ever injured his/her mouth or teeth, even as an infant? If yes, please explain the circumstances and age of occurrence:
At what age did your child stop:
Bottle/Breast Feeding? Sipper Cup?

9

HABITS

Does your child do any of the following habits? YES/NO If yes, please circle:
LIP SUCKING/LICKING THUMB/FINGER SUCKING TONGUE/CHEEK BITING
PEN/PENCIL CHEWING NAIL BITING PACIFIER
CLENCHING/GRINDING ICE CRUNCHING TONGUE THRUSTING
TOBACCO PRODUCTS GOING TO BED WITH BOTTLE OR SIPPER CUP

10

MEDICAL HISTORY

Child's Physician/Pediatrician: City/State: Phone #:

Are your child's immunizations up to date? YES/NO (circle one)

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

Please circle either YES or NO

YES/NO Heart Murmur/Congenital Heart Defect YES/NO Frequent Headaches
YES/NO Liver/Stomach Problems YES/NO HIV/AIDS
YES/NO Kidney Problems YES/NO Frequent Hospitalizations
YES/NO Adenoidectomy/Tonsillectomy YES/NO Cerebral Palsy
YES/NO Arthritis YES/NO Diabetes/Endocrine Problems
YES/NO Frequent Ear Infections YES/NO Congenital Birth Defect
YES/NO Premature Birth YES/NO Easily Bruised
YES/NO Asthma (Date of last attack) YES/NO Cancer/Tumors/Blood Disease
YES/NO What triggers the attack? YES/NO Mental Delay
YES/NO Hearing/Vision Problems YES/NO Seizure Disorder
YES/NO Major Injury YES/NO (Date of Last Seizure)
YES/NO Breathing/Lung Problems YES/NO Rheumatic Fever
YES/NO Speech Problems YES/NO Physical Delay
YES/NO Sleep Apnea/Snoring YES/NO Is your child undergoing Psychological Treatment or Counseling?
YES/NO Hyperactivity/Attention Deficit Disorder
YES/NO Autism Please Explain:

MEDICATIONS

Please list drug name, dosage, and frequency of the following:

Is your child currently taking any Prescription Medications, even on an as needed basis?

Is your child currently taking any Over the Counter Medications?

Is your child currently taking any Herbal Therapies?

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE PRECEDING QUESTIONS AND CERTIFY TO THE TRUTH OF ALL INFORMATION GIVEN. I WILL NOT HOLD DR. WINN OR ANY MEMBER OF HER TEAM RESPONSIBLE FOR ERRORS OR OMISSIONS I HAVE MADE IN THE COMPLETION OF THIS FORM. I UNDERSTAND THAT THE INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES. I GIVE DR. WINN PERMISSION TO USE SUCH MEASURES AS DEEMED NECESSARY IN HER PROFESSIONAL JUDGMENT TO RENDER A DIAGNOSIS FOR MY CHILD. ALL DIAGNOSTIC AIDS, SUCH AS X-RAYS AND MODELS, ARE THE PROPERTY OF THIS OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED BY MY FAMILY, REGARDLESS OF INSURANCE COVERAGE AND THAT PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. IF MY ACCOUNT REQUIRES SERVICING BY A COLLECTION AGENCY, I UNDERSTAND THAT I WILL BE LIABLE FOR THE COLLECTION FEES AND ANY APPLICABLE COURT COSTS, IN ADDITION TO MY OUTSTANDING BALANCE. I ALSO REQUEST THAT PAYMENT UNDER MY DENTAL INSURANCE BE MADE PAYABLE TO DR. TERRI WINN ON ANY SERVICES PROVIDED FOR MY FAMILY. I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ANY FUTURE CLAIMS. THIS AUTHORIZATION SHALL CONTINUE INDEFINITELY UNLESS REVOKED BY ME IN WRITING. THE KIDS' DENTIST DOES NOT ASSUME AND LIABILITIES FOR CHILDREN WHILE THEY ARE PLAYING ANYWHERE ON THE KIDS' DENTIST PREMISES. PARENTS/ACCOMPANYING ADULTS ARE EXPECTED TO SUPERVISE THEIR CHILDREN WHILE PLAYING BY SIGNING. BY SIGNING BELOW, PARENT/GUARDIAN RELEASES THE KIDS' DENTIST FROM ALL LIABILITY FOR ANY INJURIES THEIR CHILD MAY RECEIVE WHILE ON THE KIDS' DENTIST PREMISES.

SIGNED

DATE

WITNESS