Cochran, Soares, and Associates

Pediatric Dentistry

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Patient Name: _____ Date of Birth: _____

Patient Sex: _____ Patient Age: _____

Parent/Guardian Name (s): _____

Cell Phone: _____ Ok to text? ☐ Yes ☐ No Work Phone: _____

Address: _____

1. Do you have any concerns about today's appointment that you'd like brought to your doctor's attention

   ☐ Yes ☐ No _____

2. Is your child presently under the care of a physician for any medical issue?

   ☐ Yes ☐ No _____

3. Is your child taking any medications?

   ☐ Yes ☐ No _____

4. Does your child have a medical condition (heart murmur, heart defect, etc.) that requires antibiotics before dental treatment?

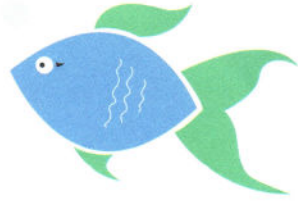
   ☐ Yes ☐ No If yes, has your child taken the prescribed medication? ☐ Yes ☐ No

   What Medication? _____ Dosage _____ When _____

5. Is your child allergic to a medicine or other products? ☐ Yes ☐ No _____
6. Is your child allergic to vinyl, metals, or other products? ☐ Yes ☐ No _____
7. Is your child allergic to latex? (balloons or other products?) ☐ Yes ☐ No
8. Are you on well water? ☐ Yes ☐ No
9. Do you drink bottled water? ☐ Yes ☐ No Brand? _____
10. Are you interested in information for athletic mouth guards? ☐ Yes ☐ No

Signature: _____ Date: _____

Relationship to patient: _____



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