**JEFFREY PEARLMAN, D.D.S., P.A.**
FAMILY DENTISTRY
CRESTWOOD DENTAL ASSOCIATES
Specializing in Children and Adolescents
18638 Crestwood Drive
Hagerstown, Maryland 21742
Telephone (301) 797-6950

DATE________________

CHILD'S NAME________________ NICKNAME____________ AGE______ BIRTHDATE ____________

SCHOOL________________ GRADE______ RESIDENCE ADDRESS________________

________________ ZIP ________ HOME NO.____________ CELL NO.____________

FATHER'S NAME________________ BIRTHDAY____________ S.S. #____________

MOTHER'S NAME________________ BIRTHDAY____________ S.S. #____________

BROTHERS______ SISTERS______ HEAD OF HOUSEHOLD'S OCCUPATION ________________

FATHER EMPLOYED BY________________ ADDRESS/PHONE ________________

MOTHER EMPLOYED BY________________ ADDRESS/PHONE ________________

IF APPLICABLE, DENTAL INSURANCE CARRIER________________ GROUP # ____________

WHOM MAY WE THANK FOR REFERRING YOU ________________

CHILD'S FAVORITE HOBBY________________ ANY PETS________________

CHILD'S FAVORITE SPORT________________

## DENTAL HISTORY

| | yes | no |
|---|---|---|
| DATE OF LAST DENTAL VISIT____________ | | |
| FOR WHAT ____________ | | |
| ____________ BY DR. ____________ | | |
| ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS ____________ | ☐ | ☐ |
| HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS ____________ | ☐ | ☐ |
| ANY INJURIES TO MOUTH, TEETH, HEAD ____________ | ☐ | ☐ |
| ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTHBREATHING, ETC. ____________ | ☐ | ☐ |
| ANY LOST TEETH ____________ | ☐ | ☐ |

| | yes | no |
|---|---|---|
| DOES YOUR CHILD BRUSH DAILY | ☐ | ☐ |
| DO YOU ASSIST YOUR CHILD WITH BRUSHING | ☐ | ☐ |
| HOW OFTEN ____________ | | |
| IS DENTAL FLOSS USED ____________ | ☐ | ☐ |
| ARE DISCLOSING TABLETS USED ____________ | ☐ | ☐ |

HOW DOES YOUR CHILD RECEIVE FLUORIDE?
☐ WATER SUPPLY ☐ TOOTHPASTE
☐ DENTIST ☐ VITAMIN ☐ TABLETS
☐ NONE ☐ OTHER ____________

CHILD'S ATTITUDE TO DENTISTRY
________________
________________
________________

## MEDICAL HISTORY

CHILD'S PHYSICIAN ____________ ADDRESS ____________ PHONE ____________

DATE OF LAST COMPLETE PHYSICAL EXAMINATION? ____________ RESULTS ____________

________________

| | yes | no |
|---|---|---|
| IS YOUR CHILD IN GOOD HEALTH? ____________ | ☐ | ☐ |
| IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? ____________ | ☐ | ☐ |
| IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? ____________ | ☐ | ☐ |

WHAT IS YOUR CHILDS - WEIGHT ____________ HEIGHT ____________

| | yes | no |
|---|---|---|
| HAS YOUR CHILD EVER BEEN HOSPITALIZED? ____________ | ☐ | ☐ |
| HAS YOUR CHILD EVER HAD SURGERY? ____________ | ☐ | ☐ |

METHOD OF INFANT FEEDING ____________________

EATING HABITS PRESENTLY - BRIEFLY EXPLAIN ____________________

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? ____________________ yes ☐ no ☐

____________________

DOES YOUR CHILD HAVE OR HAS HE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

| | yes | no |
|---|---|---|
| 1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE ____ | ☐ | ☐ |
| 2. CONGENITAL HEART DISEASE OR HEART MURMUR ____ | ☐ | ☐ |
| 3. ALLERGIES: A) FOOD, DUST, ETC. ____ | ☐ | ☐ |
| B) DRUG, i.e. Penicillin, etc. | ☐ | ☐ |
| C) UNKNOWN ____ | ☐ | ☐ |
| 4. ASTHMA OR HAY FEVER ____ | ☐ | ☐ |
| 5. ARTHRITIS OR RHEUMATISM (PAINFUL, SWOLLEN JOINTS) ____ | ☐ | ☐ |
| 6. DIABETES OR BLOOD SUGAR PROBLEMS ____ | ☐ | ☐ |
| 7. ANY PROLONGED BLEEDING OR BRUISES EASILY ____ | ☐ | ☐ |
| 8. KIDNEY OR BLADDER PROBLEMS ____ | ☐ | ☐ |
| 9. ANEMIA OR BLOOD DISORDERS ____ | ☐ | ☐ |
| 10. TUBERCULOSIS OR PNEUMONIA ____ | ☐ | ☐ |
| 11. LIVER PROBLEMS, JAUNDICE OR HEPATITIS | ☐ | ☐ |
| 12. GLANDULAR OR HORMONAL PROBLEMS ____ | ☐ | ☐ |
| 13. ACCIDENTS OR SEVERE INFECTIONS ____ | ☐ | ☐ |
| 14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY ____ | ☐ | ☐ |
| 15. HIGH / LOW BLOOD PRESSURE ____ | ☐ | ☐ |
| 16. SPEECH, LEARNING, OR HEARING DISORDERS ____ | ☐ | ☐ |
| 17. CHILDHOOD ILLNESSES ____ | ☐ | ☐ |
| 18. IMMUNIZATIONS ____ | ☐ | ☐ |
| 19. OTHER, IF SO EXPLAIN ____ | ☐ | ☐ |

IF YES, PLEASE EXPLAIN ____________________

____________________

SUMMARY: (FOR DOCTOR'S USE)

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED ____________________

____________________

____________________

HISTORY TAKEN FROM

____________________ RELATIONSHIP ____ RECORDED BY ____ DATE ____

SUBSEQUENT HISTORIES BY:

NAME ____ RELATIONSHIP ____ RECORDED BY ____ DATE ____

NAME ____ RELATIONSHIP ____ RECORDED BY ____ DATE ____

NAME ____ RELATIONSHIP ____ RECORDED BY ____ DATE ____

## AUTHORIZATION FOR TREATMENT UPON A MINOR

Patient's Name ____________________

Birth Date ____________________

The undersigned parent or guardian of the above-named minor patient, hereby requests and authorizes the performance of dental services upon said patient. Furthermore, the undersigned does hereby authorize the performance by Dr. Pearlman or any authorized persons within his dental practice of any and all procedures as may in the judgment of Dr. Pearlman be necessary for the proper treatment and care of said minor patient. The undersigned further authorizes the administration to said patient of any and all anesthetics and analgesics as may be deemed necessary or appropriate by Dr. Pearlman.

The undersigned further expressly assumes all financial obligation for any and all services as may be provided by Dr. Pearlman or any authorized persons within his practice for the treatment and care of said minor patient.

Payment of all charges is due immediately upon provision of professional services. In the event of nonpayment of such charges, and referral of the subject account to an attorney for collection, the undersigned agrees to pay, in addition to the principal amount and interest due upon said account, attorney's fees in the amount of 20% of such past due balance.

Date ____________

Witness ____________________ ____________________ (SEAL)

Relationship to Patient ____________