DEBORAH A. ASHCRAFT, D.M.D., P.C.
PEDIATRIC AND ADOLESCENT DENTISTRY

PERIODIC EXAM UPDATE

Date: _____ Child's Date of Birth: _____

_____ _____ _____
Child's Name Mailing Address City/State/Zip Code

_____ _____ _____
Home Phone # Mother's Work # Father's Work #

1) Is there a change in the mother's or father's place of employment? ❑ Yes ❑ No
New place of employment _____

2) Has his/her medical history changed since their last visit? ❑ Yes ❑ No
_____

3) Is he/she taking any medications at this time? ❑ Yes ❑ No If yes, what?_____
_____

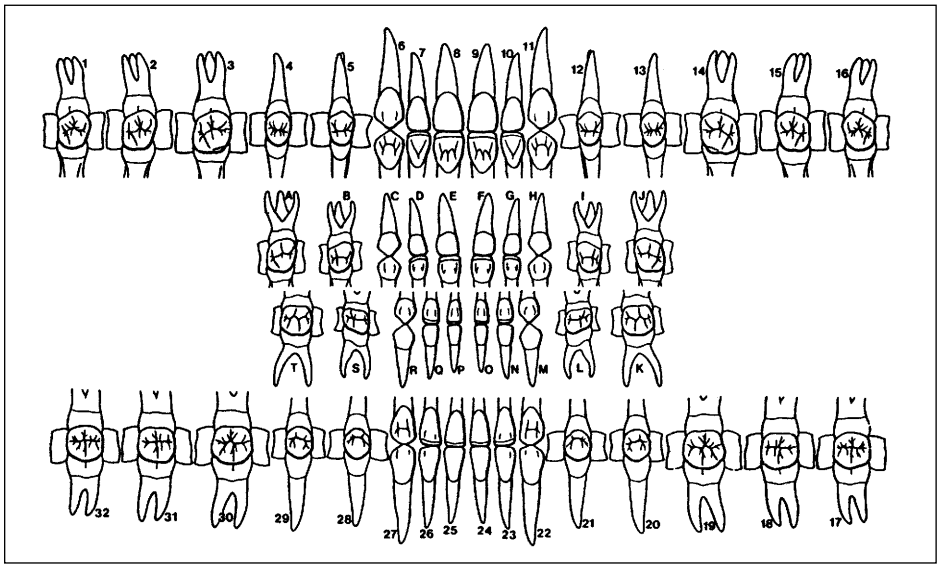
4) Has he/she had any recent dental problems or habits – such as thumb, finger, or pacifier sucking habits?
❑ Yes ❑ No If yes, what? _____
_____

5) Is your child taking systemic fluoride supplements (tablets, drops or fluoride in vitamins)? ❑ Yes ❑ No

6) Has your dental insurance or payment method changed? ❑ Yes ❑ No

7) If the Dr. feels X-rays are needed at this visit, do we have your permission to take them? ❑ Yes ❑ No

8) Comments concerning your child's dental health?
_____
_____



Med Hx.: _____
Drug Allergies:_____
_____
Soft Tissue:_____
OH: G F P
Gingivitis;_____
Calculus:_____
Habits: _____
Trauma: _____
Term Plane: R _____ L _____
Molar Rel: R _____ L _____
X Bite _____ Overbite _____%
Overjet _____ mm Openbite _____mm
Midline Dev. _____ _____
TMJ Click: R _____ L _____

Thank you for your assistance in keeping our records up to date.

I authorize release of any necessary information to process insurance claims.

Please sign: _____ Date:_____