Deborah A. Ashcraft, DMD, PC

PEDIATRIC & ADOLESCENT DENTISTRY

PERIODIC EXAM UPDATE

Date: _____ Child's Date of Birth: _____

_____	_____	_____
Child's Name	Address	City/State/Zip Code
_____	_____	_____
Home Phone #	Mother's Cell #	Father's Cell #
_____	_____	_____
Alternate Phone #	Alternate Phone #	Alternate Phone #

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, please list? _____

   _____

4) Has he/she had any recent dental problems or habits – such as thumb, finger, or pacifier sucking habits?

❑ Yes ❑ No If yes, please list? _____

_____

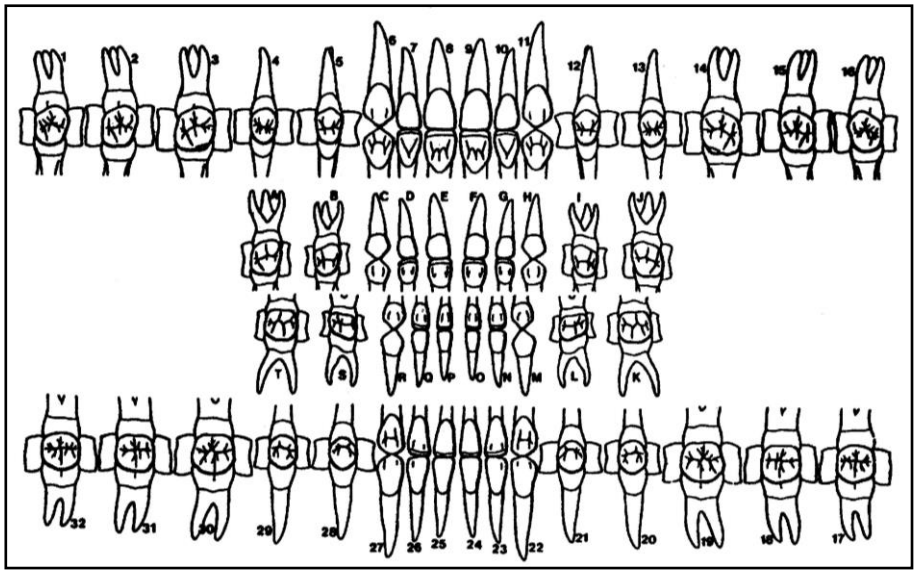
5) Is your child taking systemic fluoride supplements (tablets, drops or fluoride in vitamins)? ❑ Yes ❑ No

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

7) If the doctor feels that X-rays are needed, 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 _____

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

Please sign: _____ Date: _____ Relationship: _____