

Indian Valley Dental Associates

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ADOLESCENT REGISTRATION AND HISTORY

In an effort to treat your young adult properly, this medical history has been developed specifically for young adults, ages 13 to 18.

Date _____
Last name _____ First name _____ Nickname _____
Date of Birth _____
Address _____ Phone _____
School _____ Grade _____
Father's Name _____ Date of Birth _____
Father Address (if different than above) _____
Home Phone _____ Cell Phone _____ Social Security # _____
Father Employed by _____
Father's Employers Address _____ Phone # _____
Mother's Name _____ Date of Birth _____
Mother's Address (if different than above) _____
Home Phone _____ Cell Phone _____ Social Security # _____
Mother Employed by _____
Mother's Employers Address _____ Phone # _____
Person Financially Responsible (if other than parent) _____
Whom may we thank for referring you _____

DENTAL HISTORY

Previous Dentist _____ Does your child brush teeth twice daily?.....Yes /No
Date of last dental visit _____ Is dental floss used?.....Yes /No
Has child complained about dental problems?.....Yes/No Is fluoride taken in any form?.....Yes /No
Any unhappy dental experiences?.....Yes/No Any unusual speech habits?.....Yes/No
Please explain: _____ Has your child had orthodontics or is currently in treatment
Patient's attitude toward dentistry _____ If so, Orthodontists' Name _____

Any other dental concerns _____

(Please see back)

ADOLESCENT HEALTH HISTORY

Physician _____ Address _____
Phone (____) _____ Date of last physical exam _____

Is child under care of physician now?..... Yes /No

Please list what types of medications : _____
*please include prescription, over the counter, fluoride & any herbal supplements

Does child have good physical coordination?.....Yes /No

Is there any excessive bleeding when cut?..... Yes /No

Has the child ever been hospitalized?.....Yes /No-- If so, for what? _____

Has the child ever had surgery?.....Yes/ No--If so, what type? _____

Is there any allergy to penicillin/ other medications?.....Yes/No--If so, which? _____

Are there any other allergies?..... Yes /No--If so, to what? _____

Are there any emotional problems?..... Yes /No--If so, please explain _____

Does the child smoke or use any form of tobacco products? Yes/ No

Females: Pregnant..... Yes/ No Birth Control Pills.....Yes/ No

Is pre-medication necessary for dental treatment.....Yes/No

DOES CHILD HAVE ANY HISTORY OF THE FOLLOWING:

Anemia	Chronic Sinus	Hearing Loss	Measles	Tuberculosis
Asthma	Convulsions/Epilepsy	Heart Murmur	Mononucleosis	Jaundice
Bladder Infections	Diabetes	Kidney Disease	Mumps	HIV/ AIDS
Cerebral Palsy	Liver Disease	Rheumatic Fever	Hepatitis	Other:_____
Chicken Pox	Fainting	Malignancies	Thyroid Disease	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that Indian Valley Dental Associates should be aware of.

During the course of treatment, local anesthetic ("novocaine") may have to be used to avoid pain. Possible side effects, while not expected, could include, but not be limited to: prolonged numbness, infection, difficulty opening, short periods of excitability, bleeding, muscle soreness, biting lip or tongue, or unknown allergic reactions.

Parent or Guardian Signature _____ Date _____

Relation to Child _____