BOULDER HOLISTIC DENTISTRY

Child's Name _____ Date of birth_____

School _____ Grade _____

Parents' name(s) _____

Home Address_____ Phone _____

_____ Phone _____

Whom may we thank for referring you? _____

Child's physician_____ Phone _____

Is the child:	in good health?	YES	NO
	under a doctor's care for any problem?	YES	NO
	taking medications now or within the last year?	YES	NO
	If yes, what?		
	following a particular diet?	YES	NO
	ever had a serious illness or operation	YES	NO

Please check if the child has ever had:

_____ Allergies

_____ Asthma

_____ Diabetes

_____ Epilepsy

_____ Bleeding problems

_____ Heart murmur

_____ Heart problems of any sort

_____ Rheumatic fever or scarlet fever

_____ Adverse reaction to penicillin, novocaine or other drugs

Has the child been to a dentist before? YES NO

Was the experience positive, neutral or negative?

Has the child lived in an area with fluoridated water? YES NO

Or taken fluoride supplements? YES NO

What brand of toothpaste does the child use?

Is there anything else we should know about the child's health and development?

Parent's signature _____ Date _____