



A. Stephen Pauly, DDS, PC

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THESE QUESTIONS ARE OF GREAT VALUE IN HELPING US GET A BETTER UNDERSTANDING OF YOUR CHILD

Child's Name _____ Nickname _____ Sex _____
 Age _____ Birth Date _____ Place of Birth _____
 Attends Which School _____ Grade _____
 Names and Ages of Brothers and Sisters _____
 Child's Physician _____ Phone # _____
 Family Dentist _____ Phone # _____

CHECK ONE

Yes No

1. Has your child had any history of epilepsy, cerebral palsy, hemophilia or bleeding problems, heart trouble, allergies, diabetes, asthma, kidney, liver or thyroid disorders? If yes, underline the condition. Yes No
2. Has your child had any unfavorable reaction to drugs, including antibiotics and local anesthesia solution? Yes No
3. Is your child allergic to any food or medicine? Yes No
4. Do you consider your child to be an unusually slow or exceptionally fast learner? If yes, underline. Yes No
5. Does your child have any special needs? If yes, kindly advise. _____ Yes No
6. Does your child have a history of thumb sucking, finger sucking, lip sucking, pacifier, nail biting, extended nursing, bottle use? If yes, underline. Yes No
7. How do you think your child will act toward the dentist? _____
8. What is your child most interested in? _____
9. How often does your child brush his/her teeth? _____
10. Is dental floss used? If so, how often? _____ Yes No
11. What do you believe is the cause of tooth decay? Please circle one.
 Heredity Tooth brushing habits Excessive Sweets Other
12. Are you interested in preventing further decay by having fluoride treatments? Yes No
13. Is your child taking any supplemental fluoride? Yes No
14. Is your child adopted? Yes _____ No _____. Does your child know? Yes _____ No _____. Yes No
15. Has Mother or Father had a lot of tooth decay? Yes No
16. Has your child had any unfavorable experiences in a dental or medical office? Yes No
17. Is your child taking any medicine (prescribed or over-the-counter)? Yes _____ No _____. What kind? _____
18. Toothache now? Yes _____ No _____. If yes: Upper Lower Right Left
19. When did the toothache begin (date)? _____
20. What relieves the pain? _____
21. When was your child's last dental care (date)? _____ Where? _____
22. Purpose of this appointment _____

Please use the back of this sheet for any comments, questions or requests which you would like to bring to Dr. Pauly's attention; or to expand on any of the information given above if additional space is required.

Parent/Guardian Information

Father's Full Name _____ Driver's License # _____
 Mother's Full Name _____ Driver's License # _____
 Mailing Address _____ City _____ State _____ ZIP Code _____
 Home Phone _____ Single _____ Married _____ Separated _____ Widowed _____ Divorced _____
 Father's Employer _____ Address _____ Business Phone _____
 Mother's Employer _____ Address _____ Business Phone _____
 Health/Dental Insurance Company _____ Policy Subscriber # _____
 Father's Social Sec # _____ Mother's Social Sec # _____
 Personal responsible for Child's Account if different from above _____
 How did you hear about our office? _____