A. Stephen Pauly, DDS, PC
1513 Riverside Avenue
Fort Collins, CO 80524
(970) 484-4255

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.	☐	☐
2.	Has your child had any unfavorable reaction to drugs, including antibiotics and local anesthesia solution?	☐	☐
3.	Is your child allergic to any food or medicine?	☐	☐
4.	Do you consider your child to be an unusually slow or exceptionally fast learner? If yes, underline.	☐	☐
5.	Does your child have any special needs? If yes, kindly advise. _____ _____	☐	☐
6.	Does your child have a history of thumb sucking, finger sucking, lip sucking, pacifier, nail biting, extended nursing, bottle use? If yes, underline.	☐	☐
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? _____	☐	☐
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?	☐	☐
13.	Is your child taking any supplemental fluoride?	☐	☐
14.	Is your child adopted? Yes _____ No _____. Does your child know? Yes _____ No _____.		
15.	Has Mother or Father had a lot of tooth decay?	☐	☐
16.	Has your child had any unfavorable experiences in a dental or medical office?	☐	☐
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? _____