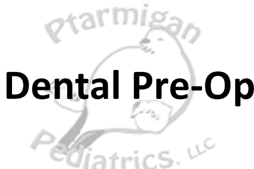
*Office Use Only*

VFC: [ ] V02 -- MDD
[ ] V03 – No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP

INSURANCE:
Copay / Co-ins

Statement Balance




# Dental Pre-Op

*Office Use Only*

WT: ________________kg
WT: ________________lb
HT: ___________________
OFC:__________________
Temp: ________________
Resp: _______________
Pulse: ________________
Oxygen: ______________
BP: _________________

**Child's Name: _____________________________________Birth Date: _____________________**

Who is your child's primary care physician? _______________________________________________________________________
Who is your child's dentist? _________________________________________________________________________________
What date is your child's surgery scheduled?________________________________________________________________________

Do you have any concerns about your child today? ____________________________________________________________________
Does your child have any allergies to medicines, foods, latex, etc.? Yes / No. If yes, which ones?
_____________________________________________________________________________________________________
Has your child had any difficulty with past immunizations? Yes / No. If yes, which ones? ____________________________________
Has your child had any surgeries? Yes / No. If yes, describe: _____________________________________________________________
Has your child been hospitalized overnight? Yes / No. Is yes, why: _________________________________________________________
Has your child or anyone in your child's family had any reactions to anesthesia? Yes / No.
If yes, please specify: ____________________________________________________________________________________________
Does your child or anyone in your child's family have any history of bleeding or easy bruising disorders or problems? Yes / No.
If yes, please specify:_____________________________________________________________________________________________
Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? ________________________________________
Is your child on any medicine/ vitamins? Yes / No. Which ones/dose? ____________________________________________________

**Health:** Is your child exhibiting any of the following symptoms?

| Symptom | Response | Symptom | Response |
|---|---|---|---|
| Ear Pain / Ear Pulling | Yes / No. If yes, how long _______________ | Fever | Yes / No. If yes, how long ___________ |
| Ear Drainage | Yes / No. If yes, how long _______________ | Headache | Yes / No. If yes, how long ___________ |
| Eye Drainage | Yes / No. If yes, how long _______________ | Cough | Yes / No. If yes, how long ___________ |
| Nasal congestion | Yes / No. If yes, how long _______________ | Shortness of breath | Yes / No. If yes, how long ___________ |
| Nasal discharge | Yes / No. If yes, how long _______________ | Chest pain | Yes / No. If yes, how long ___________ |
| Sore Throat | Yes / No. If yes, how long _______________ | Neck pain | Yes / No. If yes, how long ___________ |
| Decreased appetite | Yes / No. If yes, how long _______________ | Rash | Yes / No. If yes, how long ___________ |
| Urinary Symptoms | Yes / No. If yes, how long _______________ | Sleep Problems | Yes / No. If yes, how long ___________ |
| Constipation / Gas | Yes / No. If yes, how long _______________ | Diarrhea | Yes / No. If yes, how long___________ |
| Abdominal pain | Yes / No. If yes, how long _______________ | Vomiting | Yes / No. If yes, how long___________ |

**Social:**
Any changes in your child's environment? (new home, pets, daycare, etc.)__________________________________________________
Is this child yours by: __ birth __ adoption __ marriage (stepchild) other ____________________________________________
Who lives in the household with the child? (Please list for all households if more than one) **Please specify relationship to child**
_____________________________________________________________________________________________________
Marital status of Parents: __ married __ unmarried __ separated __ divorced __living together __ other: _______________________
Does this child live with you full-time? ____ Other? (Please describe)_____________________________________________________
Who is the primary caretaker in the home? ________________________________ Name of Dentist? __________________________
Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? ___________________________________________
Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: __________________________________________
Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: __________________________________________
Is your child in daycare or school? Yes / No. If yes, where/who/grade? ____________________________________________________
Do you have any pets in your home? Yes / No. Which kind/how many? ______________________________________________

**This form completed by:** ______________________________ **Relationship to Child:** _____________________ **Today's Date**____________________