Dr. Rena Christman
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Chippewa Falls, WI 54729
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FIRST NAME ☐ M ☐ F	AGE	BIRTHDATE	TODAY'S DATE

PHYSICAN NAME AND PHONE NUMBER(S)	DATE OF LAST PHYSICAL EXAM

WHO MAY WE THANK FOR THIS REFERRAL? _____

IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSCIAN? ☐YES ☐NO IF SO, WHY? _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐YES ☐NO IF SO,WHEN AND WHY? _____

IS YOUR CHILD SEEN AT OTHER CLINICS IN THE HOSPITAL? ☐YES ☐NO IF SO, WHAT CLINICS AND HOW OFTEN?

ALLERGIES: _____

ALLERGIES TO MEDICATIONS: _____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? ☐YES ☐NO IF YES, PLEASE LIST MEDICATIONS

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS:

Anemia	☐Y	☐N	☐UNSURE	HIV/AIDS	☐Y	☐N	☐UNSURE
Asthma	☐Y	☐N	☐UNSURE	Hyperactivity/ADHD	☐Y	☐N	☐UNSURE
Autism	☐Y	☐N	☐UNSURE	Kidney Disease	☐Y	☐N	☐UNSURE
Birth Defects	☐Y	☐N	☐UNSURE	Learning Disabilities	☐Y	☐N	☐UNSURE
Bleeding Problems	☐Y	☐N	☐UNSURE	Liver Disease	☐Y	☐N	☐UNSURE
Blood Disorders	☐Y	☐N	☐UNSURE	Mental Retardation	☐Y	☐N	☐UNSURE
Blood Transfusion	☐Y	☐N	☐UNSURE	Muscular Dystrophy	☐Y	☐N	☐UNSURE
Cancer	☐Y	☐N	☐UNSURE	Pregnant	☐Y	☐N	☐UNSURE
Cerebral Palsy	☐Y	☐N	☐UNSURE	Psychiatric Problems	☐Y	☐N	☐UNSURE
Chronic Ear Infection	☐Y	☐N	☐UNSURE	Radiation Therapy	☐Y	☐N	☐UNSURE
Cystic Fibrosis	☐Y	☐N	☐UNSURE	Rheumatic Fever	☐Y	☐N	☐UNSURE
Delayed Speech Development	☐Y	☐N	☐UNSURE	Seizures	☐Y	☐N	☐UNSURE
Development Delay	☐Y	☐N	☐UNSURE	Sexually Transmitted Diseases	☐Y	☐N	☐UNSURE
Diabetes ___ I ___II	☐Y	☐N	☐UNSURE	Sickle Cell Anemia	☐Y	☐N	☐UNSURE
Down's Syndrome	☐Y	☐N	☐UNSURE	Skin Disorders	☐Y	☐N	☐UNSURE
Emotional Problems	☐Y	☐N	☐UNSURE	Sleep Apnea	☐Y	☐N	☐UNSURE
Epilepsy	☐Y	☐N	☐UNSURE	Snoring	☐Y	☐N	☐UNSURE
G-Tube Feeding	☐Y	☐N	☐UNSURE	Spina Bifida	☐Y	☐N	☐UNSURE
Hearing Loss/Impairment	☐Y	☐N	☐UNSURE	Tuberculosis	☐Y	☐N	☐UNSURE
Heart Condition/Murmur	☐Y	☐N	☐UNSURE	Tumors	☐Y	☐N	☐UNSURE
Hepatitis ___ A ___B ___C	☐Y	☐N	☐UNSURE	X-Ray Treatment (not dental)	☐Y	☐N	☐UNSURE
Herpes	☐Y	☐N	☐UNSURE	Trouble chewing or swallowing (Strong Gag Reflex)	☐Y	☐N	☐UNSURE
High Blood Pressure	☐Y	☐N	☐UNSURE	Syndrome (specify) _____			

PLEASE EXPLAIN ALL "YES/UNSURE" RESPONSES AND ANY OTHER PROBLEMS/CONDITIONS YOUR CHILD MAY HAVE: _____

DENTAL HISTORY

FAMILY DENTA HISTORY ☐MISSING/EXTRA TEETH ☐DECAY ☐UNDERBITE/OVERBITE/JAW SURGERY ☐OTHER _____

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? ☐YES ☐NO IF NO, DATE OF LAST DENTAL EXAMINATION _____

IS THIS AN EMERGENCY VISIT? ☐YES ☐NO IF YOUR CHILD IS HAVING A DENTAL PROBLEM, PLEASE SPECIFY:

HOW DO YOU THINK YOUR CHILD WILL REACT TO THIS DENTAL VISIT? ☐COOPERATIVE ☐UNCOOPERATIVE ☐NOT SURE

PLEASE EXPLAIN YOUR RESPONSE: _____

IF YORU CHILD HAS SEEN A PREVIOUS DENTIST PLEASE LIST THE NAME AND PHONE NUMBER BELOW:

SIGNATURE PARENT/GUARDIAN: _____ RELATIONSHIP: _____