Richard D. Kubicek, D.D.S., P.C.
920 2nd Street
Friend, NE 68359

Child's Name:_____ Date:_____
Parent's Name:_____ Date of Birth:_____
Home Address:_____ Home Phone:_____
_____
Father's Place of Employment:_____ Work Phone:_____
Mother's Place of Employment:_____ Work Phone:_____
Child's Physician:_____ Office Phone:_____

Health History

Is your child allergic to anything, including medications? If so what?

_____
_____

Has your child ever had any of the following:

	Yes	No		Yes	No
Asthma	☐	☐	Handicaps/Disabilities	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐
Hepatitis	☐	☐	Diabetes	☐	☐
HIV/AIDS	☐	☐	Rheumatic Fever	☐	☐
Hemophilia	☐	☐	Congenital Heart Defect	☐	☐
Abnormal Bleeding	☐	☐	Heart Murmur	☐	☐
Allergies	☐	☐	Convulsions/Epilepsy	☐	☐
Latex Allergies	☐	☐	Banana or Egg Allergy	☐	☐

Please explain any medical problems that your child has:_____
_____
_____

Child's Habits

How often does your child brush?_____
How often does your child floss?_____

List all the medications your child takes:_____
_____
_____
_____
_____

Does your child do any of the following:	Yes	No
Suck finger/thumb? or suck/bite lips?	☐	☐
Bite/Chew nails? clench jaws? grind teeth?	☐	☐
Chew hard objects? (pencils, etc.)	☐	☐
Is your water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.
I also authorize the dental staff to perform the necessary dental services my child may need.

Signature:_____ Date:_____
(Parent or Guardian)