Today's Date: _____

TELL US ABOUT YOUR CHILD

Patient Name: _____ Child's preferred name: _____

Birthdate: _____ Age: _____ Sex: ____ School: _____ Grade: _____

Address: _____ City: _____ Zip: _____

Names and ages of other children in the Family: _____

Siblings we treat: _____

PARENT INFORMATION

Parent/Guardian: _____ Relationship to patient: _____

Birthdate: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Social Security #: _____

Address if different than above: _____

Parent/Guardian: _____ Relationship to patient: _____

Birthdate: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Social Security #: _____

Address if different than above: _____

Who has primary custody of the patient? _____

Parent's marital Status: ___ Married ___ Single ___Divorced ___Separated ___Partnered ___Widowed

Whom does child reside with? ___Mom ___Dad ___Both ___Other _____

YES **NO** Is your child adopted? If yes, please provide important details: _____

YES **NO** May we confirm appointments by text? If yes, preferred number: _____

YES **NO** May we confirm appointments by email? If yes, preferred email: _____

Whom may we thank for referring you to us? _____

What is the reason for the child's dental visit? _____

FINANCIAL INFORMATION

YES **NO** Does your child have dental insurance? If yes, please complete information below:

Subscriber: _____ DOB: _____ SSN: _____

Employer: _____ Insurance Company: _____

Mail Claims to: _____ Phone:_____

Subscriber ID: _____ Group number: _____

Who is the person responsible for payment of the account? _____

MEDICAL HISTORY

YES NO Is your child in good health? Comments you wish to share: _____

Name of child's physician?_____ Phone: _____

Date of last physical exam? _____Child's Weight:_____ Height:_____

Preferred pharmacy: _____ Pharmacy phone : _____

YES NO Were there any problems at birth/ premature birth? _____

YES NO Has your child ever had a health problem? _____

YES NO Are your child's immunizations up to date _____

YES NO Is your child taking any medications, vitamins or dietary supplements? If yes which ones:

_____

YES NO Is your child allergic to any of the following:

___Aspirin ___Penicillin ___Food ___Latex ___Jewelry ___Codeine ___Sulfa ___Metals ___Erythromycin

YES NO Does your child have any allergies to items or specific foods not listed above?

If yes to what: _____

YES NO Has your child ever had surgery? If yes, explain: _____

YES NO Did your child have a reaction or problem with anesthesia? If yes, explain: _____

YES NO Is there a family history of a reaction or problem with anesthesia? _____

YES NO Has your child ever been hospitalized? If yes, explain: _____

YES NO Does your child have frequent exposure to tobacco smoke? If yes, how often:_____

YES NO Are there any psychological or emotional problems you would like to bring to our attention? If yes, explain:

_____

YES NO Does your child adjust well to new situations? _____

Do you consider your child to be

____Advanced in the learning process ____Progressing Normally ____Delayed in the learning process

PLEASE INDICATE IF YOUR CHILD HAS BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING:

YES	**NO**	Behavioral, emotional, or psychiatric problems	**YES**	**NO**	Attention deficit/hyperactivity disorder (ADD/ADHD)
YES	**NO**	Problems with physical growth or development defects, syndromes or inherited conditions	**YES**	**NO**	Abuse (physical, psychological, emotional, sexual neglect
YES	**NO**	Developmental disorders, learning problems/delays	**YES**	**NO**	Autism/Autism spectrum disorder
YES	**NO**	Cerebral palsy, brain injury, epilepsy/seizures	**YES**	**NO**	Bladder or kidney problems
YES	**NO**	Impaired vision, hearing or speech	**YES**	**NO**	Gastroesophageal/acid reflux (GERD), stomach ulcer
YES	**NO**	Sleep apnea/snoring, mouth breathing	**YES**	**NO**	Diabetes, hyperglycemia, hypoglycemia
YES	**NO**	Congenital heart defects/disease, heart murmur, rheumatic fever or rheumatic heart disease	**YES**	**NO**	Asthma, reactive airway disease, wheezing or breathing problems
YES	**NO**	Anemia, sickle cell disease/trait, blood disorder, bruise easily	**YES**	**NO**	Rash, hives, eczema or skin problems
YES	**NO**	Jaundice or liver problems	**YES**	**NO**	Cancer, chemo, radiation

If YES to any of the above, please provide more details here: _____

_____

_____

_____

DENTAL HISTORY

What is your primary concern about your child's oral health? _____

How do you expect your child will respond to dental treatment? ___Excellent ___Good ___Fair ___Poor

YES NO Has your child ever been examined by another dentist?

If YES: Date of first visit: _____ Date of last visit: _____ Reason: _____

YES NO Has your child had dental x-rays taken? _____ Date of x rays: _____

YES NO Has your child had local anesthesia (novocaine)? _____

YES NO Has your child had nitrous oxide during a dental procedure?

YES NO Has your child ever had a difficult dental appointment or unfavorable reaction?

If YES, describe:_____

YES NO Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?

If YES, name of orthodontist: _____

YES NO Is there anything we should know before treating your child?

If YES, describe:_____

YES NO Does your child participate in sports or similar activities **?** _____

YES NO Does your child wear a mouthguard during these activities? _____

Does your child have any of the following?

YES NO Mouth sores or fever blisters	**YES NO** Bleeding gums/ gum infection
YES NO Clenching/grinding teeth	**YES NO** Cavities/decayed teeth
YES NO Bad breath	**YES NO** Jaw joint problems (clicking, popping, pain when chewing or yawning)
YES NO Excessive gagging	
YES NO Toothache	
YES NO Injury to teeth, mouth or jaw If YES, when: _____ Type of injury: _____	**YES NO** Sucking habit after one year of age: If YES, which: ___Finger ___Thumb ___Pacifier For how long? _____

ORAL HYGEINE AND FLUORIDE

How would you describe: Your child's oral health? ___Excellent ___Good ___Fair ___Poor

Your oral health? ___Excellent ___Good ___Fair ___Poor

The oral health of your other children? ___Excellent ___Good ___Fair ___Poor

YES NO Is there a family history of cavities?

How often does your child brush his/her teeth? _____ times per _____

YES NO Does someone help your child brush?

How often does your child floss his/her teeth? _____ times per _____

YES NO Does someone help your child floss?

What type of toothbrush does your child use? _____

What type of toothpaste does your child use? _____

What is the source of drinking water at home? ___City/community ___Private/well ___Bottled water

Please check all sources of fluoride your child receives

____Drinking water ____Toothpaste ____Over the counter rinse ___Prescription

___Fluoride treatment in the dental office ___Fluoride treatment by pediatrician/other practitioner

DIET

YES NO Does your child eat three meals each day?
YES NO Is your child lactose intolerant?
YES NO Is your child on a special restricted diet? If yes, explain: _____
YES NO Does your child suffer from any nutritional deficiencies? If yes, explain: _____
YES NO Is your child a "picky" eater? If yes, explain: _____
YES NO Does your child have a diet high in sugar or starches? If yes, explain: _____

How frequently does your child have the following?

Candy or other sweets: ___Rarely ___1-2 times/week ___3-4 times/week
Product: _____
Chewing Gum: ___Rarely ___1-2 times/week ___3-4 times/week
Product: _____
Snacks between meals: ___Rarely ___1-2 times/week ___3-4 times/week
Usual Snacks: _____
Drinks (other than water): ___Rarely ___1-2 times/week ___3-4 times/week
Product: _____

FAMILY MEDICAL AND DENTAL HISTORY

Which member of the immediate family has a history of (circle family member):
Allergies: MOM DAD SIBLING Allergic to: _____
History of cavities: MOM DAD SIBLING **No/minimal cavities:** MOM DAD SIBLING
Extra or missing teeth: MOM DAD SIBLING GRAND PARENT Which did they have extra or missing: _____
Had orthodontic treatment: MOM DAD SIBLING If YES, name of orthodontist: _____

SUPPLEMENTAL QUESTIONS IF CHILD IS INFANT OR TODDLER

YES NO Was your child born prematurely? If YES, what week? _____
YES NO Was your child breast fed? ___Less than 6 months ___6-11 months ___12-23 months ___2 years or more
YES NO Was your child bottle fed? ___Less than 6 months ___6-11 months ___12-23 months ___2 years or more
YES NO Do/did you feed your child infant formula?
YES NO Does/did your child sleep with a bottle?
YES NO Does your child use a no-spill training cup (sippy cup)?

Child's age (in months) when first tooth appeared in mouth _____
YES NO Has your child experienced any teething problems?
When did you start brushing your child's teeth?
___N/A ___Less than 6 months ___6-11 months ___12-23 months ___2 years or more
When did you being using fluoridated toothpaste?
___N/A ___Less than 6 months ___6-11 months ___12-23 months ___2 years or more

OUR OFFICE IS HIPPA COMPLIANT & IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MADE by OSHA, the CDC, & the ADA

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent/Guardian: _____ Date: _____