Pediatric Dental Health Associates, LTD.

Licensed Specialists in Pediatric Dentistry Serving infants, Children, Adolescents and Patients with Special needs since 1980

Welcome to our practice! Our staff will do whatever we can to make this dental experience pleasant for you and your child. Please complete this form thoroughly; information is essential to help us better understand your child.

Basic Information About Your Child

Child's Name: _____Nickname_____ Sex: M F (circle)
First Middle Last
DOB: _____Age _____ Place of Birth_____ Social Security #: _____
Current School: _____Grade:_____
Name(s) and age of brother(s) & sister(s)
_____
Have any other children in your family been a patient in this office before? YES or NO
If YES please provide names_____
In the past, has your child had any bad past dental/medical experience? YES or NO
If YES please explain: _____
Please check any of the following that may describe your child:
( ) Outgoing ( ) Shy ( ) Bubbly ( ) Anxious ( ) Frightened ( ) Defiant ( ) Cranky
( ) Suspicious ( ) Moody ( ) High Strung ( ) Regular kid ( ) Friendly ( ) Cooperative ( ) Overtired
Child's favorite interest/sport: _____ Name (s) of pet(s): _____
How do you expect your child to react to his/her visit today?
( ) Excellent, no concerns ( ) Fair, some anxiety ( ) Poor, very fearful ( ) Uncertain/don't know
How may we help to make this a positive we experience for your child? _____
What is your specific concern today? _____
Name of family dentist: _____
Whom may we thank for referring you to our office? _____
Address of referral: _____

Dental Information

Yes No

( ) ( ) Is this your child's first dental visit? If no, what is the date of the most recent visit? _____
Please describe **what** was done and by **whom**? _____

( ) ( ) Was your child bottle fed? If yes, until what age? _____

( ) ( ) Was your child breast fed? If yes, until what age? _____

( ) ( ) Has your child ever had any injuries to his/her teeth, mouth, head, or jaws? If yes, describe _____
_____

( ) ( ) Does your child brush his/her teeth daily?

( ) ( ) Does an adult assist with the brushing? If yes, who assists? _____

( ) ( ) Does your child floss daily?

( ) ( ) Does an adult assist with the flossing? If yes, who assists? _____

( ) ( ) Does your child do any professional modeling? If esthetics is a primary concern, please explain _____
_____

Does your child have any of the following mouth habits?

( ) finger sucking ( ) thumb sucking ( ) uses a pacifier ( ) tongue thrusting
( ) mouth breather ( ) teeth grinding ( ) lip sucking ( ) Other _____

Does your child receive fluoride in any of the following forms?

( ) in vitamins ( ) in water supply ( ) in tablets/drops-Dosage: _____mg/day ( ) in toothpaste ( ) in rinse/gel

How much of these beverages does your child drink each day?

Water _____ cups Juice _____ cups Sweetened Soda [i.e. Coke, Mountain Dew] _____ cups
Milk _____ cups Gatorade _____ cups Vitamin Water _____ cups

Medical Information

Child's Pediatrician: _____ Address: _____
Phone: _____ Date of last physical: _____
Is your child in good health? Yes ( )No ( ) Is your child adopted? Yes ( )No ( ) Are your child's immunizations up to date? Yes ( )No ( )
Does your child need to be pre-medicated (with antibiotics) before dental treatment? Yes ( ) No ( )
Is your child being treated for any condition presently? Yes ( ) No ( ) If so, explain _____
Has your child ever been hospitalized or had surgery? Yes ( ) No ( ) If so, explain_____
Does your child have any allergies or reactions to any medications? Yes ( ) No ( ) If so, explain_____
Does your child have any of the following allergies?
Latex ( ) Pollen ( ) Food ( ) Food dyes ( ) Dust ( ) Others ( ) _____
List all medication, supplements and vitamins your child currently takes _____
Does your child communicate verbally? Yes ( ) No ( ) Please indicate your child's developmental age. _____
Does your child currently receive or has your child ever had speech therapy? Yes ( ) No ( ) If yes please provide dates _____

Please check **Yes** or **No** for each item			Please check **Yes** or **No** for each item			Please check **Yes** or **No** for each item		
Yes	No		Yes	No		Yes	No	
( )	( )	ADHD/ADD	( )	( )	Cleft lip/palate	( )	( )	Leukemia
( )	( )	Aids/Hepatitis	( )	( )	Convulsions/seizures	( )	( )	Nutritional deficiency
( )	( )	Allergies to medications	( )	( )	Diabetes	( )	( )	Oral ulcers
( )	( )	Anemia	( )	( )	Developmental delay	( )	( )	Orthopedic problems
( )	( )	Autism Spectrum	( )	( )	Downs syndrome	( )	( )	Premature birth
( )	( )	Asthma	( )	( )	Ear infections/problems	( )	( )	PT or OT issues
( )	( )	Autism	( )	( )	Emotional disturbances	( )	( )	Rheumatic fever
( )	( )	Birth defects	( )	( )	Epilepsy	( )	( )	Scoliosis
( )	( )	Bladder conditions	( )	( )	Eye problems	( )	( )	Sensory Integration Issues
( )	( )	Blood transfusion	( )	( )	Excessive bleeding	( )	( )	Sickle Cell Anemia
( )	( )	Bone or joint problems	( )	( )	Excessive gagging	( )	( )	Sinus problems
( )	( )	Brain injury	( )	( )	Fainting or dizziness	( )	( )	Spina Bifid
( )	( )	Bruising easily	( )	( )	Hearing/Speech problems	( )	( )	Syndrome_____
( )	( )	Cancer or Malignancies	( )	( )	Heart Problems	( )	( )	Thyroid gland disorder
( )	( )	Cerebral Palsy	( )	( )	Hemophilia/bleeding disorder	( )	( )	Tonsil/Adenoid Infection
( )	( )	Child/Sexual abuse	( )	( )	Hyperactivity	( )	( )	Tuberculosis
( )	( )	Chronic headaches	( )	( )	Genetic disorder	( )	( )	Vision Issues
			( )	( )	Kidney/Liver disease	( )	( )	Other_____

Please describe <u>any</u> current special needs, medical treatment including drugs, pending surgery, recent injuries, hospitalizations or any other evaluations your child has had.

General Information

Does the child live with both parents? Yes ( ) Father only ( ) Mother only ( ) Shared custody ( ) Other ( )
If the child has step parents, please list their names here _____

Parent #1 full name _____
Address_____
City _____State _____Zip_____
Home #_____ Office #_____
Cell #_____ Pager# _____
E-mail Address_____
DOB_____ SS# _____
Driver's License #_____
Occupation_____
Employer_____
Company Name_____
Who is responsible for your child's account? _____
Who is the child's legal guardian?_____
Signature of Parent / Guardian_____

Parent# 2 full name _____
Address_____
City _____State _____Zip_____
Home #_____ Office #_____
Cell # _____ Pager # _____
E-mail Address_____
DOB _____ SS #_____
Driver's License #_____
Occupation_____
Employer_____
Company Name_____
_____
_____
_____Date_____

Initials of staff member reviewing form: _____