

**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 or F (circle)  
First Middle Last

DOB: \_\_\_\_\_ Age \_\_\_\_\_ Place of Birth \_\_\_\_\_ Social Security #: \_\_\_\_\_

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name(s) and age(s) 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 dental or medical experiences? 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 or her visit today?

- ( ) Excellent, no concerns    ( ) Fair, some anxiety    ( ) Poorly, very fearful    ( ) Uncertain/don't know

How may we help to make this a positive 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. \_\_\_\_\_

Please indicate if your child has 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. \_\_\_\_\_

Please check if your child has 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 <b>yes</b> or <b>no</b> for each item.	Please check <b>yes</b> or <b>no</b> for each item listed.	Please check <b>yes</b> or <b>no</b> for each item listed.
Yes No	Yes No	Yes No
( ) ( ) HIV/AIDS/Hepatitis	( ) ( ) Cleft lip/palate	( ) ( ) Kidney/Liver disease
( ) ( ) Allergies to medications	( ) ( ) Convulsions/seizures	( ) ( ) Leukemia
( ) ( ) Anemia	( ) ( ) Diabetes	( ) ( ) Nutritional deficiency
( ) ( ) Autism Spectrum	( ) ( ) Developmental delay	( ) ( ) Oral ulcers
( ) ( ) Asthma	( ) ( ) Down syndrome	( ) ( ) Orthopedic problems
( ) ( ) Autism	( ) ( ) Ear infections	( ) ( ) Premature birth
( ) ( ) Birth defects	( ) ( ) Emotional disturbances	( ) ( ) PT or OT Issues
( ) ( ) Bladder conditions	( ) ( ) Epilepsy	( ) ( ) Rheumatic fever
( ) ( ) Blood transfusion	( ) ( ) Eye problems	( ) ( ) Scoliosis
( ) ( ) Bone or joint problems	( ) ( ) Excessive bleeding	( ) ( ) Sensory Integration Issues
( ) ( ) Brain injury	( ) ( ) Excessive gagging	( ) ( ) Sickle Cell Anemia
( ) ( ) Bruising easily	( ) ( ) Fainting or dizziness	( ) ( ) Spina Bifida
( ) ( ) Cancer or Malignancies	( ) ( ) Hearing/Speech problems	( ) ( ) Syndrome _____
( ) ( ) Cerebral Palsy	( ) ( ) Heart Problems	( ) ( ) Tonsil/Adenoid Infection
( ) ( ) Child/Sexual abuse	( ) ( ) Hemophilia	( ) ( ) Tuberculosis
( ) ( ) Chronic headaches	( ) ( ) Hyperactivity	( ) ( ) Vision Issues _____

Please describe any 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 \_\_\_\_\_ Parent #2 full name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Office # \_\_\_\_\_ Home # \_\_\_\_\_ Office # \_\_\_\_\_

Cell # \_\_\_\_\_ Pager # \_\_\_\_\_ Cell # \_\_\_\_\_ Pager # \_\_\_\_\_

E-Mail address \_\_\_\_\_ E-Mail address \_\_\_\_\_

DOB \_\_\_\_\_ SSN: \_\_\_\_\_ DOB \_\_\_\_\_ SSN: \_\_\_\_\_

Drivers License # \_\_\_\_\_ Drivers License # \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Company name \_\_\_\_\_ Company name \_\_\_\_\_

Company address \_\_\_\_\_ Company address \_\_\_\_\_

Who is responsible for your child's account? \_\_\_\_\_

Who is the child's legal guardian? \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Initials of staff member reviewing form: \_\_\_\_\_