KIDS DENTAL

1. Child's Information

Child's Name _____ Child's Birth date _____ Child's Age _____
First Middle Last

Nickname _____ Male FemaleSiblings that we have treated _____

Child's Home # (_____) _____

Child's Home Address _____
Street City State Zip

2. Who may we thank for referring you to our office? _____

3. Parent 1 Information

Name _____ Mother /Father Stepmother/father Guardian

Home Address, if different _____
Street City State Zip

Home Phone # (____) _____ Cell Phone # (____) _____

Employer _____ Work Phone# (____) _____

SS # _____ Parent 1 Birth date _____

Parent's Email _____

4. Parent 2 Information

Name _____ Mother /Father Stepmother/father Guardian

Home Address, if different _____
Street City State Zip

Home Phone # (____) _____ Cell Phone # (____) _____

Employer _____ Work Phone# (____) _____

SS # _____ Parent 2 Birth date _____

Parent's Email _____

5. Who Is Accompanying the Child Today? _____ Who is Financial responsible for child? _____

Do you have legal custody? YES NO If no, please indicate guardian _____

Pharmacy Name _____ Pharmacy Address: _____ Pharmacy Number_____

Who do you authorize to bring your child to the office and consent to treatment (please list person's name and relationship to the child):

_____

_____

_____

6. Dental History

___ First visit to a dentist? If NO, when was last visit to dentist and previous dentist's name? _____

_____

___ X-rays taken/date _____

___ Any history of lip/tongue tie, if so, was it released, when and by whom? _____

___ Nursing or bottle issues (currently or past history)
___ Feeding issues (currently or past history)
___ Gaggy/choking with solids
___ Airway/Sleep issues
___ History of Sleep study
___ ENT evaluation/surgery
___ Speech issues/therapy
___ Has/Had orthodontic treatment
___ Any teeth sensitive to hot/cold/biting
___ Any injury to face, mouth, or teeth

_____

___ Any serious or difficult problem associated with previous dental work, if so please list?

_____

HABITS: Check all that apply:

___ Lip Sucking/Biting/Nails
___ Pacifier/Thumbsucking/Fingersucking
___ Spitting out Toothpaste
___ Grinding/Clenching
___ Snoring
___ Fluoride toothpaste
___ Patient brushes teeth
___ Parents assist with Brushing
___ Flossing
___ Non-Fluoride toothpaste
___ History of Nursing
___ Still Nursing
___ History of Bottle or Sippy Cup
___ Still Using Bottle or Sippy Cup

Anyone in family congenitally MISSING teeth? YES NO

Why did you bring your child to the dentist today?

_____

_____

_____

_____

7. Medical History Check all that apply the child ever had?

___ ALLERGY – Amoxicillin
___ ALLERGY – All Nuts
___ ALLERGY – Almonds
___ ALLERGY – Amoxicillin
___ ALLERGY – Augmentin
___ ALLERGY - Azithromycin
___ ALLERGY – Cefdinir
___ ALLERGY – Cherry
___ ALLERGY – Codeine
___ ALLERGY – Dairy
___ ALLERGY – Egg
___ ALLERGY – Erythromycin
___ ALLERGY – Food
___ ALLERGY – Food Dyes
___ ALLERGY – Gluten
___ ALLERGY - Hazelnut
___ ALLERGY – Keflex
___ ALLERGY – Latex
___ ALLERGY – Milk/Lactose
___ ALLERGY – Omnicef
___ ALLERGY – Peanut
___ ALLERGY – Sesame
___ ALLERGY – Soy
___ ALLERGY – Strawberry
___ ALLERGY - Sulfa
___ ALLERGY – Tree Nuts
___ ALLERGY – Walnuts
___ ALLERGY – Zithromax

Any other ALLERGIES:_____

_____

___ Any Hospital Stays/Surgery:_____

___ Any of the following: ___ ADD ___ ADHD ___ AUTISM ___ NOS ___ PDD

___ Congenital Birth Defects: _____

___ Learning Disabilities _____

___ Speech therapy _____

___ Occupational therapy _____

___ Other therapy: _____

___ Asthma/Reactive airway
___ Anxiety
___ Arthritis
___ Bleeding Disorder
___ Cancer
___ Celiac's Disease
___ Celebral Palsy
___ Cystic Fibrosis
___ Epilepsy/Seizures
___ Depression
___ Diabetes
___ Down's Syndrome
___ Hearing impairment
___ Heart Murmur/Heart Defect
___ Hemagioma
___ Hemophilia
___ Hepatitis
___ HIV/AIDS
___ Kidney Conditions
___ Liver Conditions
___ MTHFR
___ Muscular Dystrophy
___ PANDAS
___ Rheumatic Fever/Scarlet Fever
___ Sensory Issues
___ Thyroid Disease

Any other serious medical conditions

_____

Please list all drugs your child is currently taking

_____

Are your child's vaccines up to date? Yes No

Child's Physician _____ Phone _____