

Pediatric Dentistry

For office use

Reviewed by: _____

Date: _____

Patient Registration and Health History

Child's Name _____ Sex _____ Date of Birth _____ Nickname _____

Name and age of siblings _____

Child's hobbies and special interests _____

Pets (type and name) _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Email _____

Who may we thank for referring you? _____

Pediatrician _____ City _____ Phone _____

Previous Dentist _____ City _____ Phone _____

Parent's Name _____ Mobile # _____

Employed by _____ Present Position _____

Parent's Name _____ Mobile # _____

Employed by _____ Present Position _____

PRIMARY DENTAL INSURANCE

* I authorize any provider to release any information regarding the dental history, treatment or benefits payable for treatment to any authorized agent for purposes of determining benefits payable. I authorize payment directly to dentist for services rendered.

SIGNATURE _____

Subscriber Name _____ Date of Birth _____ SS# _____

Employer Name _____ Address _____

Insurance Company _____ Effective Date _____ Phone _____

Address _____

Subscriber # _____ Group # (if applicable) _____

Medical Insurance Plan _____

SECONDARY DENTAL INSURANCE

* I authorize any provider to release any information regarding the dental history, treatment or benefits payable for treatment to any authorized agent for purposes of determining benefits payable. I authorize payment directly to dentist for services rendered.

SIGNATURE _____

Subscriber Name _____ Date of Birth _____ SS# _____

Employer Name _____ Address _____

Insurance Company _____ Effective Date _____ Phone _____

Address _____

Subscriber # _____ Group # (if applicable) _____

Medical Insurance Plan _____

MEDICAL HISTORY

Has your child been seen by a physician during the last 12 months..... YES NO

Is your child under medical care at present? If so, for what reason?..... YES NO

Does your child have any possible or confirmed allergies?..... YES NO

Medication _____ Food _____ Other _____

Is your child taking any medication now?..... YES NO

What medication? _____ Why? _____

Has your child ever been hospitalized?..... YES NO

When? _____ Why? _____

Has your child had any operations?..... YES NO

When? _____ Why? _____

Has general anesthetic ever been administered to your child?..... YES NO

Any complications? Please describe _____ YES NO

Does your child bruise easily?..... YES NO

Has your child ever bled excessively from a cut or injury?..... YES NO

Has your child had any of the following? (Check all that apply)

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Emotional disabilities | <input type="checkbox"/> Hearing or Speech difficulties | |

Please describe _____

How does your child accept his/her pediatrician? _____

DENTAL HISTORY

Is this your child's first visit to the dentist? If no, date of last visit _____ YES NO

Procedures done _____ Child's reaction _____

Have dental radiographs been taken? When? _____ YES NO

Reason for this visit _____

Describe your child's temperament and probable reaction to dental treatment _____

How often are your child's teeth brushed? _____ Do you help brush?..... YES NO

How often is floss used? _____ Do you help floss?..... YES NO

Is your drinking water fluoridated?..... YES NO

If not, does your child receive fluoride supplements?..... YES NO

Did your child ever take a bottle or sippy cup to bed?..... YES NO

Does your child have any habits which might affect the mouth or teeth? (Check all that apply)

- Breathes through mouth Tongue thrust/habit Sucks thumb or fingers

Pacifier If yes, until what age? _____

Please describe the parent's history of dental decay: high, average, or low

Mother _____ Father _____

SIGNATURE _____ Date _____

Relationship to patient _____