Patient Information

Patient's Name: ______________________ Patient's Date of Birth: ______________________
Patient Gender: ______________________ Address 1: ______________________
Address 2: ______________________ City: ______________________
State: ______________________ Zip Code: ______________________
Cell Phone Number: ______________________ Home Phone Number: ______________________
Email address: ______________________

Dental History (New Patients Only)

Is this your child's first dental visit?: ____
If no, please list previous Dental Office: ______________________
Were any x-rays taken at previous office? ____
If your child has had any prior radiographs, please transfer all records prior to your child's appointment.

New and Existing Patients

Has your child ever had difficulty receiving dental care? ____ If yes, please explain: ______________________

Have your child's teeth ever been injured? ____ If yes, please explain: ______________________

Who brushes your child's teeth at home? ______________________ How often? ____________
Is your child using fluoride toothpaste? ____
Are your child's teeth being flossed at home? ______________________ How often? ____________
Is your child currently taking/ has your child previously taken a fluoride supplement? ____
Does your child have any sucking habits (i.e. thumb sucking, pacifier)? ____
Has your child had any sucking habits history (i.e. thumb sucking, pacifier)? ____ If yes, please explain ____________

Does your child go to bed with a bottle or sippy cup? ____ If yes, what is the liquid? ______________________
Does your child have a family history of congenitally missing teeth? ____

Please circle if your child is having problems with any of the following:

- ☐ Cavities
- ☐ Toothache
- ☐ Abscess
- ☐ Sensitive Teeth
- ☐ Wisdom Teeth
- ☐ Mouth Breathing
- ☐ Trauma
- ☐ Gum Infection
- ☐ Color of Teeth
- ☐ Grinding or Clenching
- ☐ Jaw Sounds
- ☐ Crowding
- ☐ Bad Breath
- ☐ Other

Other: (please explain): ______________________

Medical History

Do you have Primary Care Physician? ____
Patient's Primary Care Physician: ________________________________ Date of last exam: ________________
Are your child's immunizations up to date? ___

Is your child presently being treated for any condition? ____

Is your child receiving any medications or drugs? ____

Has your child ever been hospitalized or had surgery? ____

Does your child have any allergies to food, medications or other? ____

Does your child have a heart condition/murmur? ____

Has your child had or currently have a history of any of the following:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANXIETY/DEPRESSION
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER
- ☐ BEHAVIORAL/SENSORY ISSUES
- ☐ BONE/JOINT ISSUES
- ☐ CANCER
- ☐ CEREBRAL PALSY
- ☐ CLEFT LIP/PALATE
- ☐ DIABETES
- ☐ DEVELOPMENTAL ISSUES
- ☐ EMOTIONAL ISSUES
- ☐ EPILEPSY
- ☐ EYE/VISION ISSUES
- ☐ FAINTING DIZZINESS
- ☐ HEARING/SPEECH ISSUES
- ☐ HEMOPHILIA
- ☐ IEP @ SCHOOL
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL ILLNESS
- ☐ NUTRITIONAL DEFICIENCY
- ☐ PREMATURE BIRTH
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY ISSUES
- ☐ RHEUMATIC FEVER
- ☐ SCOLIOSIS
- ☐ SEIZURES
- ☐ SICKLE CELL ANEMIA
- ☐ SINUS ISSUES
- ☐ STOMACH ISSUE /ULCERS
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ OTHER

ADOLESCENT ISSUES

- ☐ ALCOHOL USE
- ☐ EATING DISORDER
- ☐ ORAL INFECTIONS
- ☐ PIERCED LIP/TONGUE
- ☐ PREGNANCY
- ☐ SMOKING
- ☐ SUBSTANCE ABUSE

Please explain any of the above and provide any other medical information we should know about your child:

Dr. Acknowledgement: ________________________

How did you hear about us? ☐ Online ☐ Social Media ☐ Friend/Neighbor ☐ Physician Office ☐ Postcard

Signature of Parent/Legal Guardian

Relationship

Date

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