Dentistry for Children

PATIENT INFORMATION

Child's legal name: _____Date of birth: ____/___/_____
Birth sex: ☐ M ☐ F Race/Ethnicity: _____ Height: _____in. Weight: _____lbs.

PEDIATRIC DENTAL HISTORY INFORMATION

Dental Concerns

What is the primary reason for today's visit?: ☐ Cleaning/Check-up ☐ Trauma/Dental Emergency ☐ Consult for Decay ☐ New Patient Exam ☐ Other: _____

Does your child have any pain or discomfort at this time? ☐ YES ☐ NO

Has your child ever experienced injury/dental trauma to the mouth, teeth, or jaw? ☐ YES ☐ NO

Has your child ever been to the dentist?: ☐ YES ☐ NO

(If Yes) Previous/Present Dentist:_____

Date of last exam:_____ Date of last X-Rays:_____

What is your child's overall feeling about the dentist? ☐ Positive ☐ Indifferent ☐ Nervous

Please provide your rationale for answer above: _____

List one or more of the patient's interests/activities:_____

Dental Habits

Does your child have any of the following dental habits? (Please check all that apply)

- ☐ Suck Thumb/Finger
- ☐ Nighttime feeding
- ☐ Bite/Chew Nails (or objects)
- ☐ Tongue Thrust
- ☐ Bottle Fed
- ☐ Use Pacifier
- ☐ Oral aversions
- ☐ Clench/Grind Teeth
- ☐ Mouth Breather
- ☐ Breast Fed
- ☐ Chews gum
- ☐ Vape or tobacco use

Hygiene Routine

Please check all hygiene habits that apply and note frequency if listed.

- ☐ Use Fluoride Toothpaste
- ☐ Consume Fluoridated Water
- ☐ Brushing by **Child** _____/day
- ☐ Use Fluoride Mouthwash
- ☐ Floss _____/day
- ☐ Brushing by **Parent** _____/day

Snack frequency or number os snacks between meals _____ (1x/day, 2x/day, 3+/day)

Please list examples of their snacks: _____

_____

PEDIATRIC HEALTH HISTORY INFORMATION

Primary physician: _____

Address/phone:_____ Last visit: _____

Is your child being actively treated by a physician at this time? (outside of routine well checks/annual exams) ☐ YES ☐ NO

Reason:_____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?
☐ YES ☐ NO List date & describe: _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ YES ☐ NO

List name, dose, frequency & date started: _____

Allergies

Does your child have any of the following allergies? (Please check all that apply)

- ☐ Latex Allergy
- ☐ Penicillin/Amoxicillin Allergy
- ☐ Codeine Allergy
- ☐ Aspirin Allergy
- ☐ Sulfa Allergy
- ☐ Hay Fever
- ☐ Food (specify):_____
- ☐ Drug/Other (specify): _____
- ☐ Environmental (specify): _____

Please describe reactions to any noted allergies: _____

Does your child require an EpiPen? ☐ YES ☐ NO

Has your child ever had a reaction to or problem with an anesthetic, sedative, antibiotic, or other medication?

☐ YES ☐ NO

Describe: _____

Is your child up to date on immunizations against childhood diseases? ☐ YES ☐ NO

Is your child immunized against human papilloma virus (HPV)? ☐ YES ☐ NO

Medical Conditions

Indicate if your child has a history of any of the following conditions. (Please check all that apply)

- ☐ Heart Murmur/Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Heart Disease/Defect/Surgery
- ☐ Abnormal Bleeding/Hemophilia
- ☐ Blood Disorder/Anemia
- ☐ Cancer/Tumor/Leukemia
- ☐ Sickle Cell Trait
- ☐ Immune Disorder
- ☐ Asthma/Reactive Airway/Breathing Problems
- ☐ Cystic Fibrosis/COPD
- ☐ Tonsillitis/Sinusitis/Chronic Adenoid Infections
- ☐ Diabetes/Hyperglycemia/Hypoglycemia
- ☐ Stomach/GI Disorders/Acid Reflux(GERD)
- ☐ Liver Disease/Jaundice/Hepatitis
- ☐ Bladder/Kidney Problems
- ☐ Autism Spectrum
- ☐ ADD/ADHD
- ☐ Epilepsy/Seizures/Convulsions
- ☐ Cerebral Palsy
- ☐ Mental/Cognitive/Social Delay
- ☐ Mental Health Conditions/Anxiety/Depression
- ☐ Tuberculosis (TB)
- ☐ Congenital Birth Defects
- ☐ Spina Bifida
- ☐ Trisomy 21/Other Syndromes
- ☐ Premature/Low Birth Weight
- ☐ Cleft Lip/Palate
- ☐ Arthritis/Muscle, Bone, Joint Problems
- ☐ Frequent Headaches/Migraines/Fainting
- ☐ Sleep Apnea/Mouth Breathing/Gagging
- ☐ Thyroid/Pituitary/Hormonal Problems
- ☐ Eating Disorder
- ☐ Speech Disorder
- ☐ Vision Problems
- ☐ Hearing Problems/Deaf
- ☐ Other (specify): _____

PROVIDE DETAILS HERE: _____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told?

☐ YES ☐ NO If YES, describe _____

_____

Is there anything else you would like us to know about your child?: _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Dentistry for Children may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists.

Parent/Guardian signature:_____ Date:_____

Patient signature (if over 18):_____ Date:_____

MEDICAL/DENTAL FOLLOW-UP (subsequent visits)
Please answer the following questions in their entirety, even if previously filled out.

Does the patient have any new or existing allergies? (drug, environmental, food, etc.) □ YES □ NO
List:_____

Is the patient taking any new medication (prescription or over the counter), vitamins, or dietary supplements? □ YES □ NO
List name, dose, & frequency: _____

Does the patient have any medical diagnoses or concerns regarding their **heart** or **breathing**……□ YES □ NO
Does your child have any pain or discomfort at this time? ……..□ YES □ NO
Are there any other updates related to the patient's medical history? ……...□ YES □ NO
If yes, please explain: _____

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