Kids First
PEDIATRIC DENTISTRY
WE KNOW HOW TO MAKE KIDS SMILE!

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Patient Information

Date: ______________________

Patient Last Name: ______________________ First Name: ______________________ Nickname: __________________

Patient DOB: ______________________ Patient Age: _____ SS#: ______________________ Male Female

Home Address: ____

City: ______________________ State: _______ Zip Code: ___________

Home #: ________________________ Mom Cell: ________________________ Dad Cell: ________________________

Email Address: ____

Emergency Contact: ________________________ Phone: ________________________

Address: ____ Relationship: ________________________

How did you find out about our office? _______________________________________ (Patient name or referral source) Parents: Married Single Separated Divorced Widowed

Custodial Parent/Grandparent: (If applicable) ____

Father's Name: ___________________________________ SS#: ______________________ DOB: __________________

Mother's Name: __________________________________ SS#: ______________________ DOB: __________________

Mother's Employer: ________________________________ Father's Employer: ________________________________

Mother's Work Number: _____________________________ Father's Work Number: ____________________________

Dental Insurance Company: ____

Subscriber's Name: _____________________________________ Subscriber's DOB: _____________________________

Subscriber's Address (If different from above) ____

ID Number: ______________________ Group Number: ______________________

Insurance Company Phone Number: ______________________

Medical History

PCP Name: ______________________ Address: __________________________________ Phone: __________________

Date of last physical examination: ______________________

Is a physician treating your child for a specific illness? Yes No; If so, for what reason? ______________________

Is your child currently on any medications? Yes No

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions to the following?

Medications___________________Foods___________________ Other____

Has your child ever been hospitalized? Yes No; If so, when and for what reason? ______________________

Are there any psychological or emotional problems you would like to bring to our attention? Yes No

Does your child have any of the following diseases or conditions?

Accidents or severe infections	Chicken Pox	Liver problems, Jaundice or Hepatitis
AIDS or AIDS related symptoms, HIV	Convulsion, Seizures or Epilepsy	Malignancies
Anemia or Blood Disorders	Diabetes	Mental Retardation
Asthma or Lung Problems	Fainting	Muscular
Autism/Autism Spectrum Disorder	Hearing	Sickle Cell Anemia
Bleeding Problems	Headache	Sinus
Blood Transfusion	Heart Murmur, Congenial Heart Disease	Speech or Learning Disorder
Cancer/Tumor	Hyperactivity ADHD	Vision Problems
Cerebral Palsy	Kidney or Bladder Problems	Other, if so, explain ___________________

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the Dentist should be aware of or that has not been covered above.

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Dental History

Is this your child's first visit to a dentist? Yes No; If not, how long since the last dental visit? ______________
Child's previous dentist: ___________________________ Address: ____
Has your child ever has any unpleasant dental experiences? ____

Does your child brush his/her own teeth? Yes No; How frequently and when? _________________________

Do you brush your child's teeth? Yes No; How frequently and when? _________________________

Does your child floss? Yes No

Does your child have any of the following habits? (Indicate ages when occurred)

Bottle at night Yes No Use a pacifier Yes No Thumb or finger sucking Yes No

Lip sucking or biting Yes No Mouth Breathing Yes No Grinds Teeth Yes No

Has your child had fluoride in any of the following forms?

Fluoride tablets or in multivitamins Yes No Not Sure

Drinking Water (community fluoridation) Yes No Not Sure

Topical Application on teeth Dentist Applied Home Rinse Home Brush on gel School Rinse

Have your child's teeth ever been injured? Yes No; When? __________________ Cause? _____________________

Does your child tend to complain of clicking, popping and crunching noises in his/her ears while chewing? Yes No

I certify that I have read and understand the information I have filled out on this form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to the health of my child. I also authorize the completion of all mutually agreed upon dental services.

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Signature **Relationship** **Date**