Kid's Dentistree

Demographic Information

Patient_____ Date_____
Name child would like to be called_____
Birthday_____ Age_____ Sex___ Race/Ethnicity____ Primary Language_____
Home Phone_____
Home Address_____
street *town* *zip code*
Names *and ages* of other children in family_____
School_____ Grade _____
Mother_____E-mail_____
Mother's SS#_____ DOB_____
Mother's Address_____ Cell Phone_____
Mother's Employer_____Phone_____
Father_____E-mail_____
Father's SS#_____ DOB_____
Father's Address_____ Cell Phone_____
Father's Employer_____Phone_____
Who has legal custody of patient?_____
Person responsible for payment of account_____
Dental Insurance: ☐ Yes ☐ No Subscriber's Name _____
Employer_____ Insurance Company_____
Claims Address _____
Insurance phone _____ Group No_____
Secondary Dental Insurance: ☐ Yes ☐ No Subscriber's Name _____
Employer_____ Insurance Company_____
Claims Address _____
Insurance phone _____ Group No_____

Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____

Health History

☐ Yes ☐ No Is your child in good health? Name of child's physician _____
Date of last physical exam_____
☐ Yes ☐ No Has your child ever had a health problem?_____
☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_____
_____
☐ Yes ☐ No Is your child allergic to anything?_____

☐ Yes ☐ No Is your child currently taking any medications? Please give medication and reason_____

☐ Yes ☐ No Were there any problems at birth?_____

Please check if your child has been treated for any of the following:

☐ Heart disease/murmur	☐ Bleeding/transfusions	☐ Asthma	☐ Blood dyscrasias
☐ Liver/GI disease	☐ Anemia	☐ Diabetes	☐ HIV/AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Cerebral palsy	☐ Congenital birth defects	☐ Personality/social	☐ Other problems
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	

Please elaborate on any items checked:_____

_____

_____

☐ Yes ☐ No Does your child see a specialist for any health problems? Please give reason, doctor and phone number

_____

Do you consider your child to be ☐ advanced in the learning process
☐ progressing normally
☐ slow in the learning process

Was your child ☐ breast fed ☐ bottle fed At what age was it stopped?____

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Name of dentist and date_____

_____

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care? Explain_____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?

☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

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

☐ Cavities	☐ Toothache	☐ Teeth Sensitive
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

Fluoride History ☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride? What?_____

Signature_____ Date _____