KID'S DENTISTREE

1101 Gandy Dancer Richmond Hill, GA 31324
Phone: (912) 756-5437
Fax: (912) 335-6575

Demographic Information

Patient_____ Date_____
Name child would like to be called_____
Birthday_____ Sex_____ 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_____Work Phone_____
Father_____E-mail_____
Father's SS#_____DOB _____
Father's Address_____Cell Phone_____
Father's Employer_____Work 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

Patient_____Date_____

□ Yes □ No Is your child in good health?

□ Yes □ No Are your child's vaccinations up to date?

□ 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 any medicines/food/substances? _____

_____

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

□ Yes □ No Has your child received general anesthesia/sedation?

□ Yes □ No Has your child ever received a blood transfusion?

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

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

□ Heart disease/murmur	□ Eye problems	□ Kidney disease	□ ADD/ADHD
□ Bleeding/transfusions	□ Speech/hearing	□ Diabetes	□ Autism Spectrum Disorder
□ Sickle cell anemia	□ Ear infections	□ Thyroid Problems	□ Brain injury
□ Anemia	□ Asthma	□ Cerebral palsy	□ Mental delays
□ Hepatitis	□ Mouth breathing	□ Seizures	□ Physical delays
□ HIV/AIDS	□ Snoring	□ Spina Bifida	□ Social delays
□ Rheumatic fever	□ Cleft lip/palate	□ Liver/GI disease	□ Congenital birth defects
□ Leukemia/cancer	□ Tuberculosis	□ Orthopedic problems	□ Other problems

Please elaborate on any items checked:_____

_____

_____

Name of Pediatrician _____Last physical exam_____

Name of Pediatric Specialists (if applicable) _____

□ Yes □ No If necessary, may we consult with these physicians?

Dental History

Patient_____Date_____

□ 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 Do you assist your child with toothbrushing? How many times/day _____

□ Yes □ No Do you assist your child with flossing? How many times/week _____

□ 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?

Was your child □ breast fed □ bottle fed At what age was it stopped?_____

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 _____

Dentist Signature _____ Date _____