

Portsmouth Pediatric Dentistry

Today's Date _____

PATIENT INFORMATION

Child's Name _____

Date of Birth _____

Nick Name _____

School Grade _____

Address _____

Home Phone _____

City _____

M _____ F _____

State and Zip _____

Mother's Name _____

Soc. Sec. No. _____

Address _____

Occupation _____

Bus. Name _____

Email _____

Bus. Phone _____

Father's Name _____

Soc. Sec. No. _____

Address _____

Occupation _____

Bus. Name _____

Email _____

Bus. Phone _____

Child's Physician _____

Telephone _____

Street and City _____

State and Zip _____

Family Dentist _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Insurance Co., Name, Address, Phone: _____

Subscriber's Name _____

Policy and/or Group # _____

Subscriber's Employer _____

Subscriber's SS# _____

Subscriber's DOB _____

PARENT RESPONSIBILITIES

I understand that I am responsible to pay for services rendered to any child at the time of service, unless other arrangements have been made.

Signature of Parent/Responsible Party _____

Date _____

Siblings: _____

(PLEASE TURN OVER)

MEDICAL HISTORY

1. Were there any difficulties during pregnancy, delivery, or the first year of life? Y N
If so, please explain. _____

2. Is a physician treating your child presently for a specific illness? _____ Y N

3. Is your child taking any medications at this time? Y N

Drug	Dose	Frequency	Reason
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4. Has your child taken any unusual medications in the past and if so please explain? Y N

5. Has your child had any allergic or unusual reactions to medications or food? Y N

6. Has your child ever been hospitalized or had any operations? If so, when and for what reason. _____ Y N

7. Is your child up to date on all of his/her immunizations? Y N

8. Does your child have any history of any of the following conditions? Check if yes.

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD or PDD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sickle Cell Dis. |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Murmur/Defect | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer or Leukemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Latex Allergy | |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Learning Problems | |

DENTAL HISTORY

1. Please check the reason(s) for seeking care at this time.

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> First dental visit | <input type="checkbox"/> Toothache/Swelling | <input type="checkbox"/> Consult |
| <input type="checkbox"/> Accident | <input type="checkbox"/> Appearance of teeth | <input type="checkbox"/> Check up |

2. If your child has been to a dentist previously, when was the visit? _____
Were X-rays taken at that time? Y N
How did your child react? _____

3. Does your child take either fluoride drops or tablets? Y N