WELCOME TO EASTOVER PEDIATRIC DENTISTRY
LET'S GET ACQUAINTED

DATE _____

TO NEW PATIENTS:
Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your child's clinical chart.

☐ MALE ☐ FEMALE

CHILD'S NAME _____ NAME CHILD GOES BY _____

AGE _____ DATE OF BIRTH _____ SCHOOL _____ GRADE _____

RESIDENCE ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER EMPLOYED BY _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ BUS. PHONE _____

FATHER'S SS# _____ DL# _____ DOB _____

MOTHER EMPLOYED BY _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ BUS. PHONE _____

MOTHER'S SS# _____ DL# _____ DOB _____

WHO MAY WE THANK FOR REFERRING YOU TO US _____

DO WE SEE THE REFERRAL'S CHILDREN _____

NAME OF PARENT'S DENTIST _____ CHILD'S PHYSICIAN _____

WHAT ARE THE CHILD'S INTERESTS _____

BROTHER'S NAME, AGES _____

SISTER'S NAME, AGES _____

We file insurance as a courtesy to our patients. The financial responsibility is ultimately that of the parent or guardian.

_____
Initials

DENTAL HISTORY

	Yes	No
Has child had regular dental visits _____	☐	☐
Were dental x-rays taken _____	☐	☐
Do you feel your child's breath is offensive at times	☐	☐
Has child complained about dental problems _____	☐	☐
_____		
Any unhappy dental experiences _____	☐	☐
_____		
Any injuries to mouth - teeth - head _____	☐	☐
_____		
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, grinds or clenches teeth, etc.	☐	☐

	Yes	No
Orthodontic appliances worn now or ever been by parent or child	☐	☐
Does your child brush teeth twice daily _____	☐	☐
Do you assist your child with tooth brushing _____	☐	☐
How often _____		
Is dental floss used _____	☐	☐
How often _____		
Snore at night _____	☐	☐
Water source: BOTTLED ☐ CITY ☐ WELL ☐		
Does child take prescription fluoride _____	☐	☐
_____		
Child's attitude to dentistry _____	☐	☐
_____		

Please fill out health history on back **(Over)**

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No
Is child under care of physician now _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐
For what? _____		
Does child need antibiotic premedication before dental care _____	☐	☐
Is there any excess bleeding when cut _____	☐	☐
Has child ever been hospitalized _____	☐	☐
Has child ever had surgery _____	☐	☐
Is there any allergy to penicillin or other drugs	☐	☐
Are there other allergies: food - pollen _____ animals - dust - latex - other _____	☐	☐

	Yes	No
Are there any developmental delays _____	☐	☐
Is child receiving any type of therapy _____	☐	☐
OT, PT, SPEECH, BEHAVIORAL, etc. _____		
please explain: _____		

DOES CHILD HAVE ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia	___ Cerebral Palsy	___ Epilepsy	___ Kidney	___ Mumps
___ Asthma	___ Chicken Pox	___ Fainting	___ Liver	___ Rheumatic Fever
___ Bladder	___ Chronic Sinus	___ Hearing	___ Malignancies	___ Stomach
___ Blood	___ Convulsions	___ Heart	___ Mastoid	___ Thyroid
___ Cancer	___ Diabetes	___ Hepatitis	___ Measles	___ Tuberculosis
Type? _____		___ HIV / AIDS	___ Mononucleosis	___ Other

Does child have any disease, condition, or problem not listed? If so, explain

_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed:

_____

_____

_____

_____

May we request release of your child's medical records for our reference ☐ yes ☐ no

Signature of responsible party _____

_____

Relationship to child _____