



# WHITE PLAINS PEDIATRIC DENTAL GROUP, PLLC

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Welcome to our office!

Child's name \_\_\_\_\_ Birth date \_\_\_\_\_ Sex: F M

Child's Social Security # \_\_\_\_\_ Name child goes by \_\_\_\_\_

Hobbies/Pets \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Name and ages of other children in family \_\_\_\_\_

Names of other children already treated in our office \_\_\_\_\_

Do parents live together?  Yes  No If not, with whom does the child live? \_\_\_\_\_

Parent or Guardian Information \_\_\_\_\_ Mother

Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Last/ First/ MI

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

SS# \_\_\_\_\_ Pager# \_\_\_\_\_ Cell# \_\_\_\_\_

Marital Status \_\_\_\_\_ Email Address \_\_\_\_\_

Parent or Guardian Information \_\_\_\_\_ Father

Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Last/ First/ MI

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

SS# \_\_\_\_\_ Pager# \_\_\_\_\_ Cell# \_\_\_\_\_

Marital Status \_\_\_\_\_ Email Address \_\_\_\_\_

Where did you hear about our office? \_\_\_\_\_

Who may we thank for referring your child? Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

In case we need to contact you and cannot do so with the provided information, please provide the following information for an alternative contact person in an emergency situation:

Name: \_\_\_\_\_ Relationship to your child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

## Child's Medical History

Name of Child's Physician/Pediatrician: \_\_\_\_\_ Date of last Medical Exam: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is your child taking any medications?  Yes  No / If yes, please explain: \_\_\_\_\_

Does your child have any food allergies?  Yes  No / If yes, please explain: \_\_\_\_\_

Does your child have any allergies to medications including antibiotics?  Yes  No

If yes, please explain: \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No

If yes, which hospital(s)? \_\_\_\_\_ When: \_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_

Do any of the following apply to your child? Please mark the appropriate column.

	Yes	No		Yes	No
Anemia	___	___	Abnormal Bleeding	___	___
Asthma	___	___	Hepatitis	___	___
Diabetes	___	___	Handicap/Disabilities	___	___
Tuberculosis	___	___	Skin Disorders	___	___
Rheumatic Fever	___	___	Heart Conditions/Murmur	___	___
Premedication needed	___	___	Nose/throat disorders	___	___
Lung disorders	___	___	Hemophilia	___	___
HIV/AIDS	___	___	Cancer/Tumors	___	___
Stomach/kidney problems	___	___	Liver problems	___	___
Convulsions/epilepsy	___	___	Ear problems	___	___
Bone problems	___	___	Speech/vision problems	___	___
Hyperactivity/ADD/ADHD	___	___	Mental/emotional disorders	___	___
Latex allergy	___	___	Premature at birth	___	___
Complications during pregnancy	___	___	Blood transfusions	___	___
Sickle Cell Disease	___	___	Eating disorders	___	___
Thyroid/Gland disorders	___	___	Headaches	___	___
Pregnancy	___	___	Genito-urinary problems	___	___

Please explain any medical conditions/issues about which you would like us to know:

\_\_\_\_\_

### Child's Dental History

Is this your child's first visit for dental care? \_\_\_ Yes \_\_\_ No

If no, please indicate the following about the previous dentist:

Name: \_\_\_\_\_ Address/City/St: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last appointment: \_\_\_\_\_

What is your reason for seeking dental care at this time? \_\_\_\_\_

Has your child ever suffered any injury to the mouth and/or teeth? \_\_\_ Yes \_\_\_ No

If so, please explain: \_\_\_\_\_

Has your child had an unfavorable dental experience? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

#### Diet & Nutrition:

Does your child sleep with a bottle? \_\_\_ Yes \_\_\_ No / If yes, what is in the bottle? \_\_\_\_\_

Is your child on a special diet? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

#### Fluoride:

Do you have Fluoride in your water? \_\_\_ Yes \_\_\_ No

Do you have well water? \_\_\_ Yes \_\_\_ No

If yes, has the well water been tested for fluoride? \_\_\_ Yes \_\_\_ No

Does your child take fluoride supplements? \_\_\_ Yes \_\_\_ No

Does your child use toothpaste with fluoride? \_\_\_ Yes \_\_\_ No

#### Oral Habits:

Does your child use a pacifier: \_\_\_ Yes \_\_\_ No

Does your child suck a thumb or finger(s)? \_\_\_ Yes \_\_\_ No

Does your child grind his/her teeth during the day and/or night? \_\_\_ Yes \_\_\_ No

#### Oral Hygiene:

How often does your child brush in a day? \_\_\_\_\_

How often does your child floss in a day? \_\_\_\_\_

Does your child get assistance with brush and flossing? \_\_\_ Yes \_\_\_ No

#### Authorization & Release:

I have answered the questions on this form as accurately as possible and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this dental office of any changes to my child's health status. I authorize the dental staff to perform the necessary dental services my child needs. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiograph and photographs for the purpose of teaching and scientific publications.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_