KIDS Dentist

Practice Limited to Pediatric Dentistry

Dental & Medical- Instructions from Kids Dentist

Please provide us with complete information about your child, so we can provide him/her with the best possible care.

1. Please enter your child's information.

First Name: _____ Last Name: _____ Date of Birth: _____

Street Address: Apt./Unit #: City:

State: Zip Code: Mobile Phone: Email:

Gender:
○ Female ○ Male
○ Unspecified

2. Child's Dental History

Never Been to the Dentist
☐ Yes ☐ No

Date of last dental care visit:

Date of last dental x-rays:

Former dentist's name: Phone #:

3. Is your child having dental problems at this time?

○ Yes ○ No

If so, please explain the dental problem

4. Check if your child has any problem with the following:

☐ Bad breath
☐ Bleeding gums
☐ Food collection between certain teeth
☐ No Issue at this time
☐ Loose teeth or broken fillings
☐ Sores or growth in the mouth
☐ Grinding teeth
☐ Other issues
☐ Sensitivity when biting
☐ Clicking or popping jaw
☐ Sensitivity to any of the following: cold, hot, sweets

Explain:

5. Have there been any injuries to the teeth? (falls, chips, etc.)

○ Yes ○ No

If so, when & where?

6. Has your child had any unfavorable dental experiences?

○ Yes ○ No ○ N/A

If so, please explain

7. Brushing and flossing habits?

	1 time a day	2 times per day	More than twice a day	Never	Every Other Day Or Less
How often does your child floss?					
How often does your child brush?					

Medical History

8. Name of your child's physician

Does your child have a primary care doctor?
☐ Yes ☐ No

Your child's physician name: _____ Phone number of your physician _____

Date of last visit: _____

9. Does your child have a heart condition that requires an antibiotic premedication for dental visits?

○ Yes ○ No

If yes, please explain: _____

10. Is your child currently taking any medications?

○ Yes ○ No

11. List medications your child is currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		
2		
3		
4		

12. Is your child up-to-date with vaccinations/immunization?

○ Yes ○ No

13. Has your child ever been hospitalized?

○ Yes ○ No

If so, reason for hospitalization and date:

_____

14. Has your child ever had any serious head injury?

○ Yes ○ No

If Yes, explain:

_____

15. Does your child have any allergies?

☐ Penicillin ☐ Sulfa Drugs ☐ Pain Medication
☐ Local Anesthetic ☐ Aspirin ☐ Latex
☐ None ☐ Other

Other

_____

16. Check if your child has or have had any of the following:

☐ Heart problems ☐ Arthritis, rheumatism ☐ Asthma
☐ Bleeding abnormally ☐ Hemophilia ☐ Cancer/Chemotherapy
☐ Diabetes ☐ Epilepsy ☐ Hepatitis
☐ Kidney disease ☐ Liver disease ☐ Respiratory disease
☐ Rheumatic fever ☐ Thyroid problems ☐ Tumor/Growths
☐ Jaundice ☐ Mumps ☐ Seizure Disorder
☐ Tuberculosis ☐ Hearing Impairment ☐ Blood Disease
☐ Liver Disease ☐ None of the above ☐ Other

If so, explain:

_____

17. Are there ANY behavioral or emotional conditions or problems that we should be aware of in order to better serve your child?

☐ ADD/ADHD ☐ Sensory Issues ☐ Autism Spectrum Disorder
_____ _____ _____
☐ Anxiety Disorder ☐ Learning Disability ☐ None
_____ _____ _____
☐ Other
_____

Explain

_____

18. Indicate any history of (check all that apply); If checked "Yes", please explain.

	Yes	No	Explain
Thumb/finger sucking/pacifier habit			
Speech problems			
Tonsils removed			
Grinding and/or clenching of teeth			
Uses mouthguard during sports			
Frequent snacker			
Mouth Breather			
Difficulty Sleeping/sleep apnea			
Smoking or vaping			

19. Is there any other Medical or Dental information that you feel we should know about your child's health?

○ Yes ○ No

If yes, please explain:

_____

Acknowledgement

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly.

There are no other medical conditions or medications/allergies that have not been listed. I am aware that i must notify the practice of any future changes.

If the patient is a minor, I affirm that I have the legal authority to consent on this child's behalf. This will serve as my electronic signature.

_____ _____

Signature Date

20. Print Name

_____

Relationship to child

_____