KENMORE Pediatric DENTISTRY

Patient Information

Patient information (please fill out completely)

PATIENT'S FULL NAME_____ Preferred Name_____
□ Male □ Female
Birthdate_____ Age____ School _____
Home Address_____City_____ State_____ Zip _____
Main Contact # (_____)_____
Number of children in the family _____ Siblings whom we treat:_____

Responsible Party #1 (please fill out completely)

□ Guardian □ Stepfather □ Other
FATHER'S NAME_____ Birthdate_____ SSN#_____
Mailing Address_____ Email _____
City_____ State_____ Zip Code_____
Occupation_____ Employer_____Work Phone_____
Home Phone_____ Cell Phone_____ Best Contact #_____
□ Married □ Single □ Divorced □ Separated □ Widowed

Responsible Party #2 (please fill out completely)

□ Guardian □ Stepmother □ Other
MOTHER'S NAME_____ Birthdate_____ SSN#_____
Mailing Address_____Email_____
City_____ State_____ Zip Code_____
Occupation_____ Employer_____Work Phone_____
Home Phone_____ Cell Phone_____ Best Contact #_____
□ Married □ Single □ Divorced □ Separated □ Widowed

With whom does this child reside? _____

How did you hear about our office?_____

Insurance information (please fill out completely)

Name of Insured_____ Relation to Patient_____
Birthdate_____ SSN#_____ Date Employed_____
Employer_____ Work Phone (_____)_____
Insurance Company_____ Group # _____
Address_____ City_____ State_____ Zip_____

Secondary Insurance information (if applicable)

Name of Insured_____ Relation to Patient_____
Birthdate_____ SSN#_____ Date Employed_____
Employer_____ Work Phone (_____)_____
Insurance Company_____ Group # _____
Address_____ City_____ State_____ Zip_____

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Dental History

Please answer all questions, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. *Thank you*.

Is this the patient's first dental visit? □ Yes □ No Has the patient been seen regularly? □ Yes □ No

Former Dentist_____ Location_____

Were radiographs taken at the previous office? □ Yes □ No □ Don't know

Has the patient had any dental treatment in the past? □ Yes □ No
Please explain_____

Has the patient ever had a difficult experience? □ Yes □ No
Please explain_____

Has the patient had any trauma to the face/mouth/teeth? □ Yes □ No
Please explain_____

Was/Is your child bottle fed or breast fed and for how long?_____

Does/did your child suck their thumb, finger or pacifier? □ Yes □ No If yes, how long? _____

How often are the teeth brushed?_____ flossed?_____ by whom?_____

Are you using fluoridated toothpaste? □ Yes □ No Is your drinking water fluoridated? □ Yes □ No

Is your child taking fluoride tablets or drops? □ Yes □ No

Has your child ever had an orthodontic evaluation or treatment (braces)? □ Yes □ No
Name of the Orthodontist_____

Does your child have any of the following habits? (check all that apply)
□ bottle at bedtime □ pacifier □ thumb sucking/finger sucking □ lip sucking
□ teeth grinding □ tongue thrust □ other:_____

Has your child ever experienced the following dental problems? (check all that apply)
□ speech problems/delay □ cavities □broken teeth □stained or discolored teeth
□dental infection/abscess □pain from teeth □popping or soreness of the jaws

Is there any other information which will assist us in providing the best possible care for your child?

Please state here_____

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Medical History

Is your child presently under the care of a physician?..... □ Yes □ No
Child's Physician_____ Phone #_____
Date of last physical exam_____ Findings_____

Is your child:

In good health?..... □ Yes □ No
Sensitive or allergic to any medications, foods or latex?..... □ Yes □ No
If yes, please list:_____
Taking any medications?..... □ Yes □ No
If yes, please list:_____
Has your child ever had any surgeries?..... □ Yes □ No
If yes, please explain:_____
Has your child ever been hospitalized?..... □ Yes □ No
If yes, for what?_____

Does your child have any history of the following conditions (please circle):

ADD/ADHD	Developmental Delay	Hyper/Hypoglycemia	Seizure/Epilepsy
Adenoid/Tonsil Problems	Diabetes	Impaired Vision	Sickle Cell Disease
Anemia	Eczema/Skin Problems	Intellectual Disability	Sleep Apnea/Snoring
Arthritis	Endocrine Disorders	Kidney Disease	Speech Disorders
Asthma	Excessive Gagging	Liver Disease	Thyroid Problem
Autism Spectrum Disorder	Fainting or Dizziness	Learning Problems/Delays	Tuberculosis (TB)
Bleeding Problem	GERD/Acid Reflux	Mononucleosis	Other – Please List:
Blood Disorder	Hearing Disorder	Motor or Muscle Disorder	
Blood Transfusion	Heart Murmur	MRSA	
Cancer	Heart Disorder	Neglect/Abuse	
Cerebral Palsy	Hepatitis	Nutritional Deficiency	
Depression	Hydrocephaly/Shunt	Rheumatic Fever	

Please feel free to elaborate on any condition circled above:

_____

Does your child have any other problems, conditions or special needs?

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Dr. Laura Stewart and staff consent to do an oral exam, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions as deemed necessary. I understand I will be consulted before another treatment is rendered.

Parent/Guardian Printed Name_____ Date_____/_____/_____

Parent/Guardian Signature_____