New Patient Dental/Health Form

Today's Date:

CHILDREN'S DENTAL CENTER OF MADISON, S.C.

1 TELL US ABOUT YOUR CHILD

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: _____ Child's Age: _____

School: _____

Siblings We Treat: _____

Special Interests: _____

Child's Home Address: _____

_____

City State Zip

Child's Home #: _____

Do we have a current Financial/Insurance form on file with up-to-date billing and insurance information? ☐ Yes ☐ No

2 DENTAL HISTORY

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If no, how long since the last visit to the dentist? _____

Previous Dentist's Name: _____

Date of Last X-Rays at Previous Dental Visits: _____

Have there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No

If yes, please explain:

Do you have any concerns regarding your child's oral health?

Does your child have any of the following habits?

- ☐ Lip Sucking / Biting
- ☐ Pacifier Use
- ☐ Bottle
- ☐ Nail Biting
- ☐ Thumb / Finger Sucking
- ☐ Breastfeeding

Does your child have any current dental issues?

- ☐ Cavities
- ☐ Toothache
- ☐ Bleeding Gums
- ☐ Cold Sores/Fever Blisters
- ☐ Bad Breath
- ☐ Teeth Grinding
- ☐ Mouth Trauma/Broken Tooth
- ☐ Sensitivity to Hot/Cold

Has your child ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

If yes, please explain:

Is your child's water fluoridated? ☐ Yes ☐ No

Is your child taking fluoride supplements? ☐ Yes ☐ No

Has your child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No

3 HEALTH HISTORY

Has your child ever had any of the following conditions?

- ☐ Anxiety/Depression
- ☐ ADD/ADHD
- ☐ High or Low Blood Pressure
- ☐ Allergies to Latex Products
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ None of the Above
- ☐ Auto Immune Disease
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Cancer
- ☐ Heart Disease
- ☐ Congenital Heart Disorder
- ☐ Developmental Delays/Disabilities
- ☐ Diabetes
- ☐ Hearing Impairment
- ☐ Hemophilia/Blood Disorders
- ☐ Hepatitis
- ☐ HIV + / AIDS
- ☐ Kidney/Liver Conditions
- ☐ Shunts
- ☐ Reflux/GI Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Convulsions/Seizures
- ☐ MTHFR

Is your child up to date on immunizations against childhood disease? ☐ Yes ☐ No

If you checked any of the above conditions, or if you would like to discuss any other medical conditions your child has had, do so below:

List all drugs your child is currently taking.

_____

List all allergies your child currently has.

_____

Child's Physician: _____

Phone #: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

4 SIGNATURE

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian

_____

Relationship to Patient

_____

Date