Rockville pediatricdental

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PATIENT INFORMATION

Patient's Name: _____
Last First MI

Nickname: _____ Male ☐ Female ☐ Birth Date: ____/____/____ Age:_____

Patient's Address: _____
Street Address Apt. #

_____
City State Zip

Patient's Home #: (____) _____

School:_____ Grade:_____

PARENT/GUARDIAN INFORMATION

Mother ☐ Father ☐ Guardian ☐

Name: _____ Birth Date: ____/____/____
Last First MI

Home#: (____) _____ Cell#: (____) _____ Work#: (____) _____

Home Address (if different from patient):_____

_____

Employer: _____ SS#: _____

Mother ☐ Father ☐ Guardian ☐

Name: _____ Birth Date: ____/____/____
Last First MI

Home#: (____) _____ Cell#: (____) _____ Work#: (____) _____

Home Address (if different from patient):_____

Employer: _____ SS#: _____

Who is accompanying the patient today? _____
Name Relationship

Who has legal custody of the patient? Mother ☐ Father ☐ Joint ☐ Other ☐ _____

Whom may we thank for referring you?_____

Other family members seen by us: _____

Reason for today's visit: _____

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DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Employer: _____

Dental Insurance Name: _____ Insurance Phone#: (____) _____

Claim Filing Address: _____
Street Address

_____
City State Zip

Policyholders Name: _____ Birth Date: ____/____/____
Last First MI

ID#: _____ Group#: _____

SS#: _____ Work Phone#: (____) _____

Relationship to patient: _____

Secondary Dental Insurance

Employer: _____

Dental Insurance Name: _____ Insurance Phone#: (____) _____

Claim Filing Address: _____
Street Address

_____
City State Zip

Policyholders Name: _____ Birth Date: ____/____/____
Last First MI

ID#: _____ Group#: _____

SS#: _____ Work Phone#: (____) _____

Relationship to patient: _____

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DENTAL HISTORY

Patient's (Previous ☐ / Present ☐) Dentist: _____

Address of Dentist: _____

Dentist Phone #: ( ) _____

Date of Last Visit: _____ Date of Last X-rays: _____

Has the patient ever had …

Unusual dental or surgical treatment of the mouth	Yes ☐	No ☐
Jaw joint pain or tenderness	Yes ☐	No ☐
Tooth injury	Yes ☐	No ☐
Local anesthetic (such as Lidocaine)	Yes ☐	No ☐
Difficulty associated with previous dental work	Yes ☐	No ☐
Nitrous oxide analgesia (laughing gas)	Yes ☐	No ☐

Fluoride in any of the following forms:

Fluoride tablets or multivitamins with fluoride	Yes ☐	No ☐
Drinking water (community tap water fluoridation)	Yes ☐	No ☐
Fluoride application by dental professional	Yes ☐	No ☐
Fluoride rinses	Yes ☐	No ☐
Fluoride toothpaste	Yes ☐	No ☐

Does the patient have any of the following habits?

Thumb or finger sucking	Yes ☐	No ☐	Mouth breathing	Yes ☐	No ☐
Nail biting	Yes ☐	No ☐	Pacifier use	Yes ☐	No ☐
Grinding of teeth	Yes ☐	No ☐	Bottle/Nursing	Yes ☐	No ☐

Does your child brush his/her own teeth? Yes ☐ No ☐ Does a parent assist? Yes ☐ No ☐

How many times per day does he/she brush? _____

How often does he/she floss? _____ Does a parent assist? Yes ☐ No ☐

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MEDICAL HISTORY

Patient's Physician: _____ Office#: ( ) _____

Address: _____
Street Address City State Zip

Is your child currently under a physicians care for a medical condition or illness? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is there any history of serious illness, hospitalization, or surgery? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you ever been told that your child needs to take antibiotics prior to dental treatment? ☐ Yes ☐ No

List all medications, both prescription and over the counter, that your child is currently taking:

_____

_____

Has your child had any of the following medical conditions or illnesses?

Abnormal Bleeding	☐ Yes	☐ No	Handicaps/Disabilities	☐ Yes	☐ No
Abuse (physical/sexual)	☐ Yes	☐ No	Hearing/Vision Impairment	☐ Yes	☐ No
ADD/ADHD/LD	☐ Yes	☐ No	Heart Defect/Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Artificial Bones/Joints	☐ Yes	☐ No	Hepatitis/Liver Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Autism/ Asperger's/PDD	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Brain Injury	☐ Yes	☐ No	Orthopedic Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Cleft Lip/Palate	☐ Yes	☐ No	Seizures/Epilepsy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sickle Cell Disease/Trait	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Gastrointestinal Disorder	☐ Yes	☐ No	Syncope (fainting)	☐ Yes	☐ No
HIV+/AIDS	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
			Other _____	☐ Yes	☐ No

If you checked yes to any of the above, please explain below.

_____

_____

Is your child allergic to any of the following:

Antibiotics/Medications	☐ Yes	☐ No	Metals/Nickel	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Plastics	☐ Yes	☐ No
Local Anesthetics (Lidocaine)	☐ Yes	☐ No	Other_____	☐ Yes	☐ No

I confirm that the information provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform the office of any changes to my child's medical status.

Signature of parent/guardian: _____ Date: _____