Great Beginnings
Pediatric Dentistry
Gentle Care for Growing Smiles

NEW PATIENT MEDICAL HISTORY

TELL US ABOUT YOUR CHILD

Name :: _____

Nickname :: _____ ☐ Female ☐ Male

Birthdate :: _____ Age :: _____

School :: _____

Siblings We Treat :: _____
Names and Ages

Home Address :: _____

_____
City State Zip

Cell :: _____

HOW DID YOU HEAR ABOUT US

_____

_____

PARENT/LEGAL GUARDIAN INFORMATION

The information in this section applies to the main legal caregiver of the child(ren)

Name :: _____

Relationship :: _____ Birthdate :: _____

Marital Status ::

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address :: _____

_____
City State Zip

Employer :: _____

Home # :: _____

Cell # :: _____

Email Address :: _____

SPOUSE/OTHER LEGAL GUARDIAN INFORMATION

*If different than above

Name :: _____

Relationship :: _____ Birthdate :: _____

Marital Status ::

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address :: _____

_____
City State Zip

Employer :: _____

Home # :: _____

Cell # :: _____

Email Address :: _____

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PERSON RESPONSIBLE FOR ACCOUNT

Name :: _____

Relationship :: _____ Birthdate :: _____

Billing Address :: _____

_____

City State Zip

Work # :: _____

Home # :: _____

Cell # :: _____

Email Address :: _____

PRIMARY DENTAL INSURANCE

Insurance Name :: _____ Policy Owner's Name :: _____

Relationship :: _____ Birthdate :: _____ Employer :: _____

WHO WILL BE ACCOMPANYING THE CHILD TO THE APPOINTMENT

*IMPORTANT: The parent or guardian who accompanies the child is legally responsible for payment at the time of service.

Name :: _____

Relationship :: _____

Do you have legal custody of this child? ☐ Yes ☐ No

HEALTH HISTORY

Has your child ever had any of the following health conditions?

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Allergies to Any Drugs
- ☐ Allgeries to Latext Products
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Cancer
- ☐ Cardiac (Heart Conditions)
- ☐ Congenital Birth Defect
- ☐ Developmental Delays/Disabilities
- ☐ Diabetes
- ☐ Hearing Impairment
- ☐ Hemophilia/Blood Disorders
- ☐ Heptatitus
- ☐ HIV+ / AIDS
- ☐ Kidney/Liver Conditions
- ☐ Pregnancy
- ☐ Reflux/GI Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Tuberculosis
- ☐ Seizures
- ☐ None of the above

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

_____

_____

List all ***drugs*** your child is currently taking :: _____

_____

List all ***allergies*** your child 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

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DENTAL HISTORY

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

If not, how long since the last visit?

Previous Dentist Name :: _____

Date of Last X-Rays :: _____

Any injuries to teeth, face, or mouth? ☐ Yes ☐ No

If yes, please explain :: _____

_____

_____

Why did you bring your child to the dentist today?

_____

_____

_____

Does your child have any of the following habits?

- ☐ Lip Sucking / Biting
- ☐ Nail Biting
- ☐ Nursing / Bottle Habits
- ☐ Thumb / Finger Sucking
- ☐ Tobacco Use

Does your child have any current dental issues?

- ☐ Cavities
- ☐ Toothaches
- ☐ Bleeding Gums
- ☐ Discolored Teeth
- ☐ Bad Breath
- ☐ Teeth Grinding
- ☐ Oral Trauma / Broken Tooth
- ☐ Sensitivity to Hot/Cold
- ☐ Infection/Abscess
- ☐ Antibiotic Treatment for Infection

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

If yes, please explain :: _____

_____

_____

Does your home have well water or city water? ☐ Well ☐ City

Is your child taking fluoride supplements? ☐ Yes ☐ No

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

Does your child brush their teeth daily with fluoridated toothpaste? ☐ Yes ☐ No

Does your child floss their teeth daily? ☐ Yes ☐ No

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. By signing this consent I indicate that I have the legal authority to grant this permission.

Signature_____ Date_____