

Today's Date _____

Portsmouth Pediatric Dentistry Patient Information

Child's Name _____
First Middle Int. Last

Nick Name _____

Address _____

City _____

State & Zip _____

Mother's Name _____

Address _____

Email _____

Father's Name _____

Address _____

Email _____

Child's Physician _____

Street and City _____

Family Dentist _____

Date of Birth _____

School Grade _____

Home Phone _____

Male _____ Female _____

Cell Number(s) _____

Soc. Security No. _____

Occupation _____

Employer _____

Business Phone _____

Soc. Security No. _____

Occupation _____

Employer _____

Business Phone _____

Telephone _____

State & Zip _____

Do you give us permission to contact you through email/ text message to confirm appointments? _____ Yes _____ No

Whom may we thank for referring you? _____

Dental Insurance Information

Insurance Company, Address, & Phone _____

Subscriber's Name _____

Policy and/or Group# _____

Subscriber's Employer _____

Subscriber's ID# and DOB _____

Parent Responsibilities

I understand that I am responsible to pay for services rendered to my child at the time of service, unless other arrangements have been made.

Signature of Parent / Responsible Party: _____ Date: _____

(PLEASE TURN OVER)

Medical History

Were there any difficulties during pregnancy, delivery, or first year of life? ___ Yes ___ No

If yes, please explain _____

Nursing/ bottle/sippy cup/ pacifier past or present? ___ Yes ___ No

Is a physician treating your child presently for a specific illness? ___ Yes ___ No

Is your child taking any medications at this time ? ___ Yes ___ No

Drug	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child up to date on all of his/her immunizations? ___ Yes ___ No

Has your child taken any unusual medications in the past? _____ ___ Yes ___ No

Has your child had any allergic or unusual reactions to medications or food ? _____ ___ Yes ___ No

Has your child ever been hospitalized or had any operations? ___ Yes ___ No

If so, when and for what reason? _____

Approximate weight of your child _____ LBS

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ADD or PDD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Heart Murmur/Defect | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Sensory Problems | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Anxiety | | |

Does your child have any history of any of the following conditions ? Check if yes.

Adolescent Section (13 and older)

Although dental personnel treat the area in and around the mouth, the mouth is part of your entire body. Health conditions or medications that you may be taking could have an import interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is your child taking an oral contraception? ___ Yes ___ No Is your child pregnant? ___ Yes ___ No

Does your child use tobacco? ___ Yes ___ No

Dental History

Please check the reason(s) for seeking care at this time.

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> First Dental Visit | <input type="checkbox"/> Toothache/Swelling | <input type="checkbox"/> Consult |
| <input type="checkbox"/> Accident | <input type="checkbox"/> Appearance of Teeth | <input type="checkbox"/> Check Up |

If your child has been to a dentist previously, when was the visit? _____

Were X-Rays taken? ___ Yes ___ No

How did your child react? _____

Does your child take fluoride supplements? ___ Yes ___ No