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Sea of Smiles
Pediatric Dentistry

Patient Name	❑ Male ❑ Female	Date of Birth

Date of last physical exam: _____ Weight: _____
Name/address/phone number of primary physician: _____
Name/address/phone number of medical specialists: _____

Is your child being treated by a physician at this time? Reason _____	❑ YES	❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	❑ YES	❑ NO
List name, dose, frequency & date started _____		
Has your child even been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ……..	❑ YES	❑ NO
List date & describe _____		
Has your child ever had a reaction to or a problem with an anesthetic? ……..……..……	❑ YES	❑ NO
Describe: _____		
Has your child ever had a reaction or allergy to an antibiotic, sedative, fluoride, or other medication? ……..……	❑ YES	❑ NO
List _____		
Is your child allergic to latex or anything else such as metals, acrylic, or dye? ……..……....	❑ YES	❑ NO
List _____		
Is your child allergic to tree nuts, soy, Birch trees, etc.? ……..……....	❑ YES	❑ NO
List _____		
Is your child up to date on immunizations against childhood diseases? ……...…..……	❑ YES	❑ NO

Mark NO after each line if none of those conditions apply to your child.
Please mark YES if your child has a history of the following conditions. For each "YES," provide details in the box at the bottom of this list.

Complications before or during birth, prematurity, birth defects, syndromes or inherited conditions ……...…	❑ YES	❑ NO
Problems with physical growth or development …….	❑ YES	❑ NO
Sinusitis, chronic adenoid/tonsil infections …….	❑ YES	❑ NO
Large tonsils, sleep apnea/snoring, mouth breathing, or excessive gagging …….	❑ YES	❑ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ……	❑ YES	❑ NO
Irregular heart beat or high blood pressure …….	❑ YES	❑ NO
RSV, Asthma, reactive airway disease, wheezing, or breathing problems ……...	❑ YES	❑ NO
Frequent colds or coughs, or pneumonia ……	❑ YES	❑ NO
Is there anyone in the child's life who smokes? ……	❑ YES	❑ NO
Jaundice, hepatitis, or liver problems ……..	❑ YES	❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ……..	❑ YES	❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ……..	❑ YES	❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ……..	❑ YES	❑ NO
Bladder or kidney problems ……	❑ YES	❑ NO
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ……	❑ YES	❑ NO
Rash/hives, eczema or skin problems ……	❑ YES	❑ NO
Impaired vision, hearing or speech ……	❑ YES	❑ NO
Developmental disorders, learning problems/delays, or intellectual disability ……..	❑ YES	❑ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ……..	❑ YES	❑ NO
Autism/autism spectrum disorder ……	❑ YES	❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness …….	❑ YES	❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ……	❑ YES	❑ NO
Attention deficit/hyperactivity disorder (ADD/ADHD) …….	❑ YES	❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment ……..	❑ YES	❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect ……..	❑ YES	❑ NO
Diabetes, hyperglycemia, or hypoglycemia ……	❑ YES	❑ NO
Precocious puberty or hormonal problems …….	❑ YES	❑ NO
Thyroid or pituitary problems …….	❑ YES	❑ NO
Anemia, sickle cell disease/trait, or blood disorder ……	❑ YES	❑ NO
Hemophilia, bruising easily, or excessive bleeding ……	❑ YES	❑ NO
Transfusions or receiving blood products ……...	❑ YES	❑ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant ……...	❑ YES	❑ NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS ……..……	❑ YES	❑ NO

PROVIDE DETAILS HERE:

_____
_____
_____

OVER⇨

Is there any other significant medical history to this child or his/her family that the dentist should be told? …….. ❑ YES ❑ NO
If YES, describe _____

_____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
your oral health?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
the oral health of your other children?	❑ Excellent	❑ Good	❑ Fair	❑ Poor

Is there a family history of cavities? ❑ YES ❑ NO If YES, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister

Has your child had an unhappy dental experience? ❑ YES ❑ NO If YES, describe: _____

_____

_____

Does your child have a history of any of the following? If YES, describe:

Inherited dental characteristics	❑ YES ❑ NO	_____
Mouth sores or fever blisters	❑ YES ❑ NO	_____
Bad breath	❑ YES ❑ NO	_____
Bleeding gums	❑ YES ❑ NO	_____
Cavities/decayed teeth	❑ YES ❑ NO	_____
Toothache	❑ YES ❑ NO	_____
Injury to teeth, mouth or jaws	❑ YES ❑ NO	_____
Clinching/grinding his/her teeth	❑ YES ❑ NO	_____
Jaw joint problems (popping, etc.	❑ YES ❑ NO	_____
Excessive gagging	❑ YES ❑ NO	_____
Sucking habit after one year of age	❑ YES ❑ NO	If yes, which: ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other For how long: _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ❑ YES ❑ NO

How often does your child floss his/her teeth? ❑ Never ❑ Occasionally ❑ Daily Does someone help your child floss? ❑ YES ❑ NO

What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ❑ City/community supply ❑ Private Well ❑ Bottled water

Do you use a water filter at home? ❑ YES ❑ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel ❑ Prescription drops/tablets/vitamins

❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrician/other practitioner ❑ Other

Does your child regularly eat 3 meals each day?	❑ YES ❑ NO	If YES, describe: _____
Is your child on a special or restricted diet?	❑ YES ❑ NO	If YES, describe: _____
Is your child a 'picky eater'?	❑ YES ❑ NO	If YES, describe: _____
Does your child have a diet high in sugars or starches?	❑ YES ❑ NO	If YES, describe: _____
Do you have any concerns regarding your child's weight?	❑ YES ❑ NO	If YES, describe: _____

How frequently does your child have the following?

Candy or other sweets	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____
Chewing gum	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Type _____
Snacks between meals	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Usual snack _____
Soft drinks*	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____

*(*such as juice, fruit-flavored drinks, sodas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)*

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities?	❑ YES ❑ NO	If YES, list: _____
Does your child wear a mouthguard during these activities?	❑ YES ❑ NO	If YES, list: _____
Has your child been examined or treated by another dentist?	❑ YES ❑ NO	

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws?	❑ YES ❑ NO	Date of most recent dental x-rays: _____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?	❑ YES ❑ NO	If YES, when? _____
Has your child ever had a difficult dental appointment?	❑ YES ❑ NO	If YES, describe: _____

How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very Poorly

Describe your child's temperament: ❑ Flexible ❑ Difficult ❑ Cautious ❑ Other: _____

Is there anything else we should know before treating your child? ❑ YES ❑ NO

If YES, describe:

_____

_____

_____

The statements on both sides of this form are to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examination, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

Signature of Parent/Guardian _____ **Relationship to Patient** _____

Print Name _____ **Date** _____