The Smile Team
PEDIATRIC DENTISTRY

Parent/Guardian Name: _____ Date: _____

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____

Preferred Name: _____ Birthdate: _____

Address: _____ Postal Code: _____

City: _____ Prov: _____

Home Phone Number: _____ Mobile Phone Number: _____

E-mail: _____

DENTAL HISTORY

Is this the child's first dental visit? Yes No

If no, what was the approximate date of last dental visit: _____

Were x-rays taken at the last dental visit? Yes No

Does the child have any of the following habits?
(Please check all that apply)

- □ Thumb Sucking
- □ Pacifier
- □ Bottle Fed
- □ Breastfed

If any of the above habits apply, is the habit current? Yes No

If any of the above habits have stopped, what age did the child break the habit? _____

What is the primary source of water for the child?

- □ Tap
- □ Bottle
- □ Filtered
- □ Well

MEDICAL HISTORY

Name of the child's physician, pediatrician, or clinic? _____

Are the child's immunizations up-to-date? Yes No
If no, reason:_____

Is the child taking any medication? Please list:
_____

Has the child ever had a cold sore? Yes No

Has the child ever had surgery or been in the hospital overnight? Yes No
If yes, what was the date and reason for surgery or hospital visit?
_____

Does the child have an allergy to latex? Yes No

Does the child have any allergies to food? Please list: Yes No
_____

Does the child have any allergies to drugs? Please list: Yes No
_____

Does the child have any behavior concerns? Yes No
If so, please explain: _____

Does the child have a developmental or constitutional delay? Yes No
If so, explain: _____
What is the child's functional age level? _____

Has the child ever had a blood transfusion? If so, what was the date? _____

Does the child have any of the following:
(Please check all that apply)

- □ Asthma
- □ AIDS, exposure to AIDS
- □ Blood Disorders (anemia, sickle cell anemia, hemophilia)
- □ Diabetes
- □ Tubes, Prostheses, Shunts
- □ Cancer
- □ Epilepsy/Seizures
- □ Hearing Loss
- □ Hepatitis or Liver Disease
- □ Skin Rash
- □ Learning Disability
- □ Sensory Processing Disorder
- □ Autism Spectrum Disorder (ASD)

If you checked any of the above conditions, please explain:
_____

Has the child had chicken pox? Yes No
If so, when: _____

Has the child had measles? Yes No
If so, when: _____

Are there any other medical conditions or syndromes from which the child suffers?
Please explain: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____