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781-444-6650

☐ 38 Pond Street
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508-520-6660

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Bedford, MA 01730
339-234-5075


**Please complete and bring to first visit**

| Reviewed by |
| --- |
| Dr. |
| Date |

# PEDIATRIC PATIENT INFORMATION & HEALTH HISTORY FORM

***In order to ensure that your child receives the best care at our office, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.***

## PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____ Nickname: _____ Sex: _____

Age: _____ Birthdate: _____ Interests/Hobbies/Pets: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Parent/Guardian Email: _____

Parent Name: _____ Employer _____ Occupation: _____

Work Phone: _____Cell Phone: _____ Work Email: _____

Parent Name: _____ Employer _____ Occupation: _____

Work Phone: _____Cell Phone: _____ Work Email: _____

Parent address (if different from above) _____

Legal Guardian (if not parent) _____

Child's primary language if not English? _____

Date of Adoption, if applicable: _____ Does patient know? _____

Name and ages of siblings: _____

Whom may we thank for referring you? _____

Whom may we contact in case of emergency (other than a parent)?

Name: _____ Relationship: _____ Home Phone: _____

Cell Phone: _____Work Phone: _____

## HEALTH PROVIDERS

Child's Physician/Pediatrician: _____ Phone #: _____

Mailing Address: _____ City: _____ State:_____Zip: _____

Child's Previous Dentist: _____ Phone #: _____

Mailing Address: _____ City: _____ State:_____Zip: _____

Patient Name: _____ D.O.B.: _____

## DENTAL HISTORY

1. Why is your child here today? _____

2. **Dental History:**
   If your child has been to a dentist previously:
   When was last visit? _____ Have X-rays been taken? ☐ Yes ☐ No When: _____
   How did your child react? _____
   Has your child had local anesthetic ("Novocaine"?) _____ ☐ Yes ☐ No
   Were there any problems? _____
   Parent/Sibling/Primary Caregiver with history of cavities ..... ☐ Yes ☐ No

3. **Fluoride:** Has your child had fluoride in any of the following forms:
   Fluoride tablets or fluoride multivitamins ..... ☐ Yes ☐ No
   Drinking water (community water fluoridation) ..... ☐ Yes ☐ No
   Professional topical application ..... ☐ Yes ☐ No

4. **Brushing:** Does your child brush their own teeth? _____ ☐ Yes ☐ No
   When do they brush? ..... ☐ AM ☐ PM ☐ After meals
   Do you help in brushing your child's teeth? ..... ☐ Yes ☐ No
   Do you or your child use dental floss in cleaning their teeth? ..... ☐ Yes ☐ No
   What kind of toothbrush do they use? ..... ☐ Hard ☐ Soft ☐ Battery

5. **Diet:** Does your child have greater than 3 between meal sugar snacks or beverages? ..... ☐ Yes ☐ No
   If yes, what do those snacks usually consist of? _____
   How much soda and juice does your child usually drink per day?_____

6. **Trauma:** Have your child's teeth ever been injured? _____ ☐ Yes ☐ No
   When (age)? _____
   Which teeth? _____
   Cause? _____
   Did your child receive treatment? _____ ☐ Yes ☐ No
   If yes, describe treatment _____

7. **Habits:** Does your child have any of the following habits? (Indicate inclusive ages)
   Bottle to sleep or nap, and if so, what is in the bottle _____ ☐ Yes ☐ No
   Breast feeding currently ..... ☐ Yes ☐ No
   Thumb or finger sucking ..... ☐ Yes ☐ No
   Pacifier sucking ..... ☐ Yes ☐ No
   Mouth breathing ..... ☐ Yes ☐ No
   Grinding of teeth ..... ☐ Yes ☐ No

8. **Oral Surgery:** Has your child received any dental or surgical treatment to the mouth? ..... ☐ Yes ☐ No
   If yes, describe: _____
   History of lingual or maxillary frenectomy? If yes, age_____

9. Is there anything else you would like to tell us about your child's dental history? ..... ☐ Yes ☐ No
   _____
   _____

Patient Name: _____ D.O.B.: _____

## MEDICAL HISTORY

10. Were there any difficulties during the pregnancy, delivery (e.g., prematurity) or 1st year of your child's life? If yes, describe? _____ ☐ Yes ☐ No

11. **Medical conditions:** Does your child have any history of the following? *(Check all that apply)*

***General Conditions***
- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever
- ☐ Liver disease
- ☐ Endocrine

***Behavior/Learning***
- ☐ ADHD
- ☐ Anxiousness/Nervousness
- ☐ Autism/PDD
- ☐ Behavior issues: Type _____
- ☐ Emotional/Psychiatric Disorder Type _____
- ☐ Learning disability Type _____
- ☐ Non-verbal

***Developmental***
- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Developmental Delay (Mental/Physical)
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type _____
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures: Type _____
- ☐ Speech prob: Type _____
- ☐ Spina bifida
- ☐ Congenital Birth defects
- ☐ Sight

***Hematological (Blood-related)***
- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood
- ☐ Blood dyscrasias

***Infections***
- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Venereal disease: Type _____
- ☐ Frequent infections Type _____

***Substance use/Abuse***
- ☐ Drug use
- ☐ Tobacco use / vaping
- ☐ Abuse (physical or sexual)

***Other***
- ☐ Cancer: Type _____
- ☐ Thyroid Disease
- ☐ Fainting/headaches (often)
- ☐ Sleep problems
- ☐ Snoring (sleep apnea)
- ☐ Syndrome: Type _____
- ☐ Joint Replacement/Prosthesis
- ☐ Pins, Plates, Screws _____
- ☐ MTHFR
- ☐ Other _____

If any boxes checked, please describe further: _____

_____

_____

12. **Medications:** Is your child CURRENTLY taking any medications?

| Drug | How much & how often? | Reason |
|---|---|---|
| | | |
| | | |
| | | |

13. **Steroid Use:** Has your child had any steroid treatments in the past 6 months? ..... ☐ Yes ☐ No

14. **Allergies:** Has your child had any allergic reactions to:

Medications or drugs? _____

Dye? _____

Latex? _____

Foods? _____

Other? _____

Patient Name: _____ D.O.B.: _____

15. **Development/ Special Needs:**
    - Does your child have difficulty talking and understanding at their age level? ☐ Yes ☐ No
    - Does your child attend a special class or school? If yes: ☐ Yes ☐ No
    - Does your child use the following to help with walking? ☐ Wheelchair ☐ Walker ☐ Yes ☐ No
    - If female, has your child had her first monthly period? ☐ Yes ☐ No

16. **Immunizations:** Does your child need immunizations or booster of immunizations? ☐ Yes ☐ No

17. Have you ever been told that your child needs to take *antibiotics before dental treatment* ☐ Yes ☐ No

18. **Hospitalizations:** Has your child ever been hospitalized? ☐ Yes ☐ No
    - If yes, when, and where?
    - Reason for hospitalization?

19. **Surgeries:** Has your child had any surgery (operations)? ☐ Yes ☐ No
    - Date(s) and age(s)?
    - For what reason(s)?
    - Was general anesthesia used? ☐ Yes ☐ No
    - Were there any complications? If yes: ☐ Yes ☐ No

20. Are there any elevated stresses happening in your home? If yes: ☐ Yes ☐ No

21. Have you or your child ever felt threatened in your home? ☐ Yes ☐ No

I hereby authorize insurance payment directly to the Chestnut Dental Associates, P.C., the dental benefits otherwise payable to me. I also authorize the completion of all agreed and necessary dental services.

**Signature:** _____ **Relationship:** _____ **Date:** _____

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