Welcome

canton pediatric dentistry

Today's Date: _____

TELL US ABOUT YOUR CHILD

_____ _____ M_____ F_____

Child's Name (First/Middle/Last) Nickname

__/__/____ _____ _____ _____

Birthdate Child's Age School Child's Home Street Address

(_____) _____

Child's Home Phone # City State Zip

TELL US ABOUT YOUR FAMILY

_____ _____

Name Relationship to Child

Do you have legal custody of child? Yes_____No_____ Other family members seen here

Who does child live with? _____ Whom may we thank for referring you?

PARENT/GUARDIAN INFORMATION

Parents' Marital Status:

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ Domestic Partners _____

Please complete one section for each parent/guardian

Name	Name
_____ M_____ F_____	_____ M_____ F_____
Relationship to Child	Relationship to Child
(_____) _____ (_____) _____	(_____) _____ (_____) _____
Home Phone # Cell Phone #	Home Phone # Cell Phone #
Employer	Employer
(_____) _____ _____	(_____) _____ _____
Work Phone # Occupation	Work Phone # Occupation
E-mail	E-mail
___-___-____ __/__/____	___-___-____ __/__/____
SSN Birthdate	SSN Birthdate
☐ Check here if address is same as child's, OR indicate below	☐ Check here if address is same as child's, OR indicate below
Address _____	Address _____

PRIMARY DENTAL INSURANCE

_____

Insured's Name

_____

Insurance Co.

_____ _____

Subscriber ID Group #

__/__/____ _____

Subscriber Date of Birth Ins. Co. Phone #

SECONDARY DENTAL INSURANCE

_____

Insured's Name

_____

Insurance Co.

_____ _____

Subscriber ID Group #

__/__/____ _____

Subscriber Date of Birth Ins. Co. Phone #

Child's Name_____ **Reason for today's visit**_____

DENTAL HISTORY

Is this your child's first visit to a dentist? Yes___No___

If no, who was the previous dentist?

_____

Date of last dental visit_____

Were any x-rays taken when your child previously visited the dentist? Yes____No____

Has your child ever had a problem associated with dental treatment? Yes____No____

Has your child ever had any pain in his/her mouth or jaw? Yes____No____

Has your child ever had any trauma to his/her head or neck? Yes____No____

Does your child brush teeth daily? Yes____No____

Do you assist in brushing? Yes____No____

Does your child floss daily? Yes____No____

Do you assist in flossing? Yes____No____

DIET HISTORY

Does/did your child:

Breast-feed? Yes____No___ Age when stopped_____

Bottle feed? Yes____No___ Age when stopped_____

Snack more than twice a day? Yes____No____

What does your child drink with meals?_____

_____

What does your child drink between meals?_____

_____

Does your child have dietary restrictions? Yes__ No__

Does your child have an eating disorder? Yes__No__

Does your child take fluoride supplements? Yes__No__

Water: City____Well_____Bottled_____

Brand of bottled water_____

MEDICAL HISTORY

Please check any of the following that your child had or presently has: ☐ **Check here if none apply**

- ☐ **ADD/ADHD**
- ☐ **Allergies**
- ☐ **Arthritis**
- ☐ **Artificial Joint/Valve**
- ☐ **Asthma**
- ☐ **Autism**
- ☐ **Bleeding Disorder**
- ☐ **Cancer**
- ☐ **Cerebral Palsy**
- ☐ **Congenital Heart Defect**
- ☐ **Diabetes**
- ☐ **Emotional Disturbance**
- ☐ **GERD/Reflux Disease**
- ☐ **Hearing Impairment**
- ☐ **Hepatitis/Liver Disorder**
- ☐ **High Blood Pressure**
- ☐ **HIV+/AIDS**
- ☐ **Hospitalization**
- ☐ **Kidney Disorder**
- ☐ **Mental Illness**
- ☐ **Pregnancy**
- ☐ **Premature Birth**
- ☐ **Physical Impairment**
- ☐ **Seizure Disorder**
- ☐ **Sickle Cell Anemia/Trait**
- ☐ **Speech Impairment**
- ☐ **Surgery**
- ☐ **Tuberculosis**
- ☐ **Vision Impairment**

Please explain any of the above checked conditions or any serious medical conditions not listed_____

_____

Is your child adopted? Yes_____No_____

Please list medication(s) your child is currently taking _____

_____

Please list medication(s) your child has had a reaction to _____

_____

Child's Physician_____**Physician's Phone# (_____)**_____

I understand that the above information represents my child's health history and that it will be held in the strictest of confidence. It is my responsibility to inform Canton Pediatric Dentistry, PLLC of any changes in my child's medical status.

_____ _____

Signature of Parent or Guardian **Date**

FOR STAFF USE ONLY:
I have verbally reviewed the medical/dental information above with the parent/guardian.
Staff Initial:
Date: