Dover Pediatric Dentistry

## Patient Information

Patient's Name: _____ Patient's Date of Birth: _____

Patient Gender: _____ Address 1: _____

Address 2: _____ City: _____

State: _____ Zip Code: _____

Cell Phone Number: _____ Home Phone Number: _____

Email address: _____

## Dental History (New Patients Only)

Is this your child's first dental visit?: ____

If no, please list previous Dental Office: _____

Were any x-rays taken at previous office? _____

*If your child has had any prior radiographs, please transfer all records prior to your child's appointment.*

## New and Existing Patients

Has your child ever had difficulty receiving dental care? ____ If yes, please explain: _____

_____

Have your child's teeth ever been injured? ____ If yes, please explain: _____

_____

Who brushes your child's teeth at home? _____ How often? _____

Is your child using fluoride toothpaste? ____

Who flosses your child's teeth at home? _____ How often? _____

Is your child currently taking/ has your child previously taken a fluoride supplement? ____

Does/did your child have any sucking habits (i.e. thumb sucking, pacifier)? ____ If yes, please explain: _____

_____

Does your child go to bed with a bottle or sippy cup? ____ If yes, what is the liquid? _____

Does your child have a family history of congenitally missing teeth? ____

Please circle if your child is having problems with any of the following:

| | | | | |
|---|---|---|---|---|
| ☐ Cavities | ☐ Toothache | ☐ Abscess | ☐ Sensitive Teeth | ☐ Wisdom Teeth |
| ☐ Mouth Breathing | ☐ Trauma | ☐ Gum Infection | ☐ Color of Teeth | ☐ Grinding or Clenching |
| ☐ Jaw Sounds | ☐ Crowding | ☐ Bad Breath | ☐ Other | |

Other: (please explain): _____

Dover Pediatric Dentistry, 750 Central Ave Suite #K, Dover, NH 03820
Email: office@doverkidsteeth.com Tel: (603) 743-6000

# Medical History

Do you have Primary Care Physician? ____

Patient's Primary Care Physician: _____ Date of last exam: _____

Are your child's immunizations up to date?____

Is your child presently being treated for any condition?____ If yes, what condition and who is the specialist?

Is your child receiving any medications or drugs?____ If yes, what are the medications and for what reason?

Has your child ever been hospitalized or had surgery?____ If yes, please explain.

Does your child have any allergies to food, medications or other?____

Does your child have a heart condition/murmur?____

Has your child had or currently have a history of any of the following:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANXIETY/DEPRESSION
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER
- ☐ BEHAVIORAL/SENSORY ISSUES
- ☐ BONE/JOINT ISSUES
- ☐ CANCER
- ☐ CEREBRAL PALSY
- ☐ CLEFT LIP/PALATE
- ☐ DIABETES
- ☐ DEVELOPMENTAL ISSUES
- ☐ EPILEPSY
- ☐ EYE/VISION ISSUES
- ☐ FAINTING DIZZINESS
- ☐ HEARING/SPEECH ISSUES
- ☐ HEMOPHILIA
- ☐ IEP @ SCHOOL/504 PLAN
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL ILLNESS
- ☐ NUTRITIONAL DEFICIENCY
- ☐ PREMATURE BIRTH
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY ISSUES
- ☐ RHEUMATIC FEVER
- ☐ SCOLIOSIS
- ☐ SEIZURES
- ☐ SICKLE CELL ANEMIA
- ☐ SINUS ISSUES
- ☐ STOMACH ISSUE /ULCERS
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ OTHER

ADOLESCENT ISSUES:

- ☐ ALCOHOL USE
- ☐ EATING DISORDER
- ☐ ORAL INFECTIONS
- ☐ PIERCED LIP/TONGUE
- ☐ PREGNANCY
- ☐ MOKING/VAPING/CHEWING TOBACCO
- ☐ SUBSTANCE ABUSE

Please explain any of the above and provide any other medical information we should know about your child:

Dr. Acknowledgement: _____

_____ _____

Signature of Parent/Legal Guardian Relationship

_____

Date

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