Dr. Nadarajah Ganeshkumar
750 Central Ave Suite #K, Dover, NH 03820

Patient Information

Patient Name: _____ DOB: _____

Patient Gender: _____ Today's date: _____

Address: _____

_____

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? _____

New and Existing Patients

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

_____

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

_____

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

Is your child using fluoride toothpaste? _____

Are your child's teeth being flossed at home? _____ How often? _____

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

Does your child have any sucking habits (i.e. thumb sucking, pacifier)? _____

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 Grinding or Clenching

Color of Teeth Crowding Jaw Sounds Bad Breath

Wisdom Teeth Snoring at Night

Other (please explain): _____

Medical History

Primary Care Physician / Clinic Name: _____

Phone Number: _____ Email Address: _____

Address: _____

_____

If needed for dental treatment, may we have your permission for Dr. Ganeshkumar to consult with this physician? _____

Is your child receiving the recommended vaccinations for childhood diseases? _____

Is your child ALLERGIC to any medicines, substances or foods? _____ If yes, please explain below:

_____

_____

Is your child taking any medications, herbal supplements, homeopathic remedies or nutritional supplements at this time? _____ If yes, please list all medications, dosages and reasons for taking below:

_____

_____

Has your child ever been admitted to a hospital? _____ If yes, please explain below:

_____

_____H

as your child ever received general anesthesia or sedation? _____ If yes, please provide details:

_____

_____

Has your child ever been abused (physical, etc)? _____ If yes, please explain below:

_____

Please circle if your child has had or currently has any of the following:

I. BLOOD, HEART & LIVER SYSTEMS

Heart Murmur
Heart Disease
High Blood Pressure
Anemia
Hemophilia
Sickle Cell Anemia
Leukemia
Rheumatic Fever
Hepatitis
AIDS
Other: _____
N/A

2. MUSCLE & NERVOUS SYSTEMS

Convulsions/ Seizures
Epilepsy
Cerebral Palsy
Spina Bifida
Other: _____
N/A

3. EYES, EARS, NOSE, THROAT & PULMONARY ORGAN SYSTEMS

Asthma
Vision Problems
Glasses or Contacts
Hearing Problems
Frequent Ear Infections
Sinus Problems
Pneumonia
Bronchitis
Frequent Sore Throat
Tuberculosis
Cleft Lip / Palate
Other: _____
N/A

4. CHILDHOOD DISEASE

Chicken Pox
Measles
Mumps
Other: _____
N/A

5. KIDNEY, BLADDER & RENAL ORGAN SYSTEMS

Renal Disease
Frequent Infections
Other:_____
N/A

6. BONES

Orthopedic Problems
Scoliosis
Other: _____
N/A

7. ENDOCRINE SYSTEM & GLANDS

Crohn's Disease
Thyroid Problems
Diabetes (Type I or II)
Other: _____
N/A

8. ADOLESCENT ISSUES

Smoking
Alcohol Use
Eating Disorders
Oral Infections
Pierced Lips/ Tongue
Substance Abuse
Pregnancy
Other: _____
N/A

9. PSYCHOLOGICAL, COGNITIVE & EMOTIONAL

IEP at School
ADD/ ADHD
Anxiety
Autism or Asperger
Clinical Depression
Behavioral or Sensory Issues
PDD
Other: _____
N/A

Please sign below to indicate that the above information is completed fully and accurately:

Parent/ Guardian Name:_____ Date: _____

Relationship to Patient: _____

How did you hear about us? Online Social Media Friend/Neighbor Physician Office Postcard