Dover Pediatric Dentistry

Patient Information

Patient's Name: _____ Patient's Date of Birth: _____ 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. Otherwise, out of pocket expenses become patient's responsibility.

New and Existing Patients

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

_____

Has 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 prescription fluoride supplement? ____

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

_____

Does/did your child have a tongue or lip tie? ____ If yes, was a frenectomy advised or performed? ____ When? _____

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 ☐ Nursing ☐ Snoring ☐ 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? ____ If yes, is it due to a congential heart condition that requires antibiotics before dental procedures? _____

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
- ☐ SMOKING / 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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