Giggles and Grins Pediatric Dentistry

Rebecca Kucera DDS

(440) 838-1234

PATIENT NAME: ____Date of Birth_________________________

Dental History

What brings you here today? ____
When was your child's last dental visit? _________ Who is the previous dentist? ______________________
Does your child brush his/her teeth daily? __ yes __ no Floss? __ yes __ no Fluoride? __ yes __ no
Is your child's water fluoridated? __ yes __ no Is your child taking fluoride supplements? __ yes __ no
Is your child currently breast/bottle feeding? __ yes __ no When was breast/bottle stopped? _________
Does your child suck his/her thumb? __ yes __ no Fingers? __ yes __ no Pacifier? __ yes __ no
Does your child bite his/her lips or fingernails? __ yes __ no
Does your child have speech difficulties? Please explain: ____
Any particular fears or experiences in the dental office? ____

Medical History

Condition	Yes	No
Abnormal Bleeding	___Yes	___No
ADD/ADHD	___Yes	___No
Allergies (Please list_____________)	___Yes	___No
Anemia	___Yes	___No
Asthma	___Yes	___No
Autism/Autism Spectrum	___Yes	___No
Cancer	___Yes	___No
Congenital Heart Defect	___Yes	___No
Convulsions/Epilepsy	___Yes	___No
Diabetes	___Yes	___No
Drug Allergies	___Yes	___No
If yes, please list: _______________________________________		
Heart Murmur	___Yes	___No
Hearing Impairment	___Yes	___No
Handicaps/Disabilities	___Yes	___No
Hepatitis	___Yes	___No
Kidney/Liver Problems	___Yes	___No
Latex Allergy	___Yes	___No
Operations/Hospital stays	___Yes	___No
If Yes, please list: _______________________________________		
Physical/psychological development delay	___Yes	___No
Rheumatic Fever	___Yes	___ No
Shunts	___Yes	___No
Tuberculosis	___Yes	___No

Please discuss any medical concerns that your child has had or currently has:

____
____
____

Name of Child's Physician: _________________

Physician's Phone # _______________________

List all medications your child is currently taking: _____________________________

____

I understand that the information that I have given is correct to my knowledge, that it will be held in strictest confidence. I will inform this office of any changes in my child's status.

Signature of Parent/Guardian:

____

Date: _____________________________________

I do hereby request and authorize the dental staff to perform necessary dental services for the above named child. I accept full responsibility for full payment of the treatment performed. The parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of Parent/Guardian: ____ Date: ____________________________