Dermody Pediatric Dentistry & Orthodontics, P.A.

TELL US ABOUT YOUR CHILD

Patient's Name _____ Nickname_____
Last First MI
Birthday ____/____/____ Age_____ Weight_____ Male ( ) Female ( ) Social Security Number _____
School _____ Grade_____
Child's Home Address _____
Street City State Zip
List names and ages of brothers and sisters _____
_____
Have any brothers and sisters been treated here before? Yes ( ) No ( )
List names and ages of brothers and sisters which have been treated _____
_____

PARENT'S INFORMATION

Person responsible for account _____
Is this account: Private ( ) Insurance ( ) Welfare ( ) Other ( )
Child lives with: Mother ( ) Father ( ) Other ( ) relationship to child_____

Father's Information
Step Dad ( ) Guardian ( )

Name_____
Last First MI
Address _____
City_____
State Zip
SS# _____ Birthdate____/____/____
Occupation _____
Employer_____
Home # _____Work # _____Ext._____
Cell # _____

Mother's Information
Step Mom ( ) Guardian ( )

Name _____
Last First MI
Address _____
City_____
State Zip
SS# _____Birthdate____/_____/____
Occupation _____
Employer_____
Home # _____Work #_____Ext._____
Cell # _____

Parent's Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated ( )
Do you have DENTAL insurance? Yes ( ) No ( ) Insured's Name _____
If yes, name of insurance company _____

GENERAL INFORMATION

1. Whom may we thank for referring you to our office? _____
If not referred, how did you hear of us? _____
2. What is your child's favorite: Pet_____ TV Show _____ Hobbie_____
School Subject _____ Sport _____ Pastime _____
3. How do you feel your child will react in the dental office? _____

MEDICAL HISTORY

Child's Physician: Name _____
Address_____City_____State_____Zip_____
Phone # _____
Does your child have regular check-ups? Yes ( ) No ( )

Is your child cooperative during medical treatments? Yes ( ) No ( ) If no, please explain_____
_____
Does your child have any current medical problems? Yes ( ) No ( ) If yes, please explain _____
_____
Please list any medications or drugs your child is taking: _____
_____
Has your child ever been hospitalized? Yes ( ) No ( ) If yes, when _____, why _____

(Please Turn Over)

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Is your child allergic to: Penicillin ( ) Antibiotics ( ) Novocain ( ) Local Anesthetics ( ) Aspirin ( ) Latex (rubber) ( )
Other ( ) _____

Has your child had any of the following: Please (x) and explain below

1. Heart Trouble ( )	8. Blood Disorders ( )	15. Developmentally Delayed ( )
2. Rheumatic Fever ( )	9. Bleeding Problems ( )	16. Autism ( )
3. Hepatitis ( )	10. Tuberculosis ( )	17. Hearing Problems ( )
4. Epilepsy ( )	11. HIV/AIDS ( )	18. Speech Difficulty ( )
5. Asthma ( )	12. Cancer ( )	19. Sight Problems ( )
6. Kidney/Liver Disease ( )	13. Emotional Problem ( )	20. Cleft Lip/Palate ( )
7. Diabetes ( )	14. Nervous Problems ( )	21. Sickle Cell Disease or Trait ( )
		22. Cerebral Palsy ( )

Others( ) explain _____
_____

DENTAL HISTORY

Has your child previously been to a dentist? Yes ( ) No ( ) If yes, whom _____
Were there any problems? _____
Has your child ever had any injuries to his/her teeth? _____
Explain circumstances and when injury occurred _____
Has your child ever had a tooth extracted? Yes ( ) No ( ) If yes, were there any problems? Yes ( ) No ( )
Explain, _____
Has your child had pain/noise/tenderness in their jaw, joint or muscle (TMJ/TMD) ? Yes ( ) No ( )
If yes, explain_____
Are there any dental problems bothering your child at this time? Yes ( ) No ( )
If yes, explain_____
How often does your child brush his/her teeth?_____ When?_____
Is dental floss used? _____ How often? _____
Does an adult supervise and help with brushing and flossing? Yes ( ) No ( )
Does your child receive fluoride in: water ( ) school ( ) supplement ( ) vitamin ( ) toothpaste ( ) rinse ( ) dental office ( )
Eating Habits: Does your child snack? Yes ( ) No ( ) If yes, how often? _____
List a few of his/her favorite snack foods _____
Did you have any problems during pregnancy? _____
Did/Does your child sleep with a bottle? Yes ( ) No ( ) What did/does the bottle contain?_____ Age stopped?_____
At what age did your child's first tooth appear?_____
Does your child have any of the following: Thumb sucking ( ) Finger sucking ( ) Pacifier ( ) Grinding teeth ( )
Lip Sucking or biting ( ) Explain _____

Is there a family history of: A. Excessive Decay: Yes ( ) No ( )
B. Missing teeth: Yes ( ) No ( )
C. Orthodontic Treatment: Yes ( ) No ( )
Explain _____

Additional Comments:
_____

_____

I understand that all the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize Dr. Dermody and his staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian_____Date____/____/____