pediatric dental center
professional corporation
29421 Ryan Road
Warren, MI 48092
(586) 754-6300
www.PDConline.com

KIDS SMILES... PEDIATRIC DENTISTRY
48621 Hayes Rd.
Shelby Park, Bldg #500
Shelby Twp., MI 48315
(586) 247-5437 (KIDS)
www.KSPDonline.com

PATIENT INFORMATION

CHILD'S FULL NAME:_____ NICK NAME:_____

CHILD'S BIRTH DATE: _____ AGE: _____ SEX: (Circle) M F

CHILD LIVES WITH: (Circle) **Both Parents** **Mother** **Father** **Guardian** **Grandparents**

CHILD'S HOME ADDRESS: _____ CITY: ZIP: _____

HOME PHONE:_____ cell phone: _____

EMAIL ADDRESS:_____ CHILD'S SS#: _____

ALTERNATE NUMBER - Emergency

(Friend, neighbor, relative, etc.)

Name: _____ Relationship to Child: _____ Phone:_____

REFERRAL SOURCE

We appreciate the referral of patients to our office and like to send a special "thank you". Whom may we thank for referring you to us?

Name: _____ Relationship: _____

PARENT INFORMATION

Father's Full Name:_____

Father Employed By:_____

Social Security #:_____

Driver's License # _____

Employer Phone #: _____

Birth Date: _____

Mother's Full Name: _____

Mother Employed By: _____

Social Security #:_____

Driver's License #:_____

Employer Phone #: _____

Birth Date: _____

DENTAL INSURANCE INFORMATION

Insured Party's Name:_____

Employer: _____

Group #:_____

Contract # _____

Relationship to Child:_____

Insurance Co.: _____

Insurance Phone #: _____

IF MORE THAN ONE INSURANCE COVERAGE, PLEASE COMPLETE:

Insured Party's Name:_____

Employer: _____

Group #:_____

Contract #:_____

Relationship to Child:_____

Insurance Co.: _____

Insurance Phone #: _____

Payment for services is required at each appointment.
The adult who brings the child to the office is financially responsible.

Child's Name: _____

It is your responsibility to inform us of any changes in your child's health. Thank you.

Family Physician or Pediatrician: _____ Phone: _____

Date of Last Visit: _____ Are all immunizations up to date? (Circle) YES NO

MEDICAL HISTORY

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
ADHD / ADD (circle)			Cystic Fibrosis			Kidney Disorder		
AIDS or HIV Positive			Developmentally Impaired			Muscular Dystrophy		
Acid Reflux / GERD			Depression			Motor Skills Delayed		
Artificial Prosthesis			Diabetes			Radiation Treatment		
Asthma			Drug Allergy			Rheumatic Fever		
Autism			Eating Disorder			Seizures		
Bleeding Disorder / Anemia			Epilepsy			Shunt		
Blood Transfusion			Hearing Impaired			Speech Delayed		
Brain / Nerve Damage			Heart Disorder / Surgery			Surgery		
Cerebral Palsy			Heart Murmur			Tuberculosis		
Chemotherapy			Hepatitis / Liver Disorder			Vision Impaired		
Counseling			Hyperactivity			Other _____		

Please explain any YES answers or other health problems: _____

_____

Medical Specialists Name: _____ Phone: _____

Is your child allergic to: ☐ Penicillin ☐ Erythromycin ☐ Ceclor ☐ Sulfa ☐ Amoxicillin ☐ Medicine ☐ None Known
☐ Food ☐ Environmental ☐ Latex ☐ Dye ☐ Acrylic

☐ Any reaction to Anesthetic? Describe _____ ☐ Other / List: _____

Is your child taking any medicine now: (Circle) YES NO List: _____

Is your child being seen by a physician? (Circle) YES NO If yes, why _____

DENTAL HISTORY

Did your child receive fluoride treatment at pediatrician? (Circle) YES NO Date: _____

Does your child have a toothache now? (Circle) YES NO Where: _____

Any previous dental experience? (Circle) YES NO Where: _____

What was done: _____ When: _____

Child's reaction: _____ Parent's reaction: _____

Main dental concerns: _____

Any injuries to front teeth? (Circle) YES NO When: _____

Has your child ever had injuries to the head or neck? (Circle) YES NO

Does your child have any oral habits? (Circle) Thumb Finger Pacifier Other: _____

Who brushes your child's teeth? _____ When: _____

Reason for today's appointment? _____

Name and ages of other children in the household: _____

DIETARY HISTORY

Do you have fluoride in your drinking water? (Circle) YES NO City Water Bottle Water Filtered Water

Does your child snack frequently? (Circle) YES NO On what? _____

Does your child drink juice frequently? (Circle) YES NO What kind? _____

Many fruit juices have natural acids which can cause cavities if taken frequently.

Does/did your child take a bottle to bed? (Circle) YES NO Explain: _____

Because your child is a minor, signed permission is required from a parent or guardian for any dental treatment.

Signature of mom, dad or legal guardian (Circle one): _____ Date: _____

Reviewed by: _____ Date: _____

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? ☐ YES ☐ NO If YES, what week? _____

What was your child's birth weight?_____

How long was your child breast-fed? ☐ N/A ☐ <6mths ☐ 6-11 mths ☐ 12-17 mths ☐ 18-23 mths ☐ 2 yrs or more

How long was your child bottle-fed? ☐ N/A ☐ <6mths ☐ 6-11 mths ☐ 12-17 mths ☐ 18-23 mths ☐ 2 yrs or more

Do/did you feed your child infant formula? ☐ YES ☐ NO If YES, what type? ☐ Ready to use ☐ Powdered ☐ Liquid Concentrate

Does/did your child sleep with a bottle? ☐ YES ☐ NO If YES, content of bottle? _____

Does/did you child us a no-spill training cup? ☐ YES ☐ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? ☐ YES ☐ NO

When did you begin brushing his/her teeth? ☐ N/A ☐ <6mths ☐ 6-11 mths ☐ 12-17 mths ☐ 18-23 mths ☐ 2 yrs or more

When did you begin using toothpaste? ☐ N/A ☐ <6mths ☐ 6-11 mths ☐ 12-17 mths ☐ 18-23 mths ☐ 2 yrs or more

Who is your child's primary care taker during the day?_____ During the evening? _____

Name/age of siblings at home: _____

_____

_____ _____

Signature of Parent/Guardian - Relationship to Child Date Signature of Staff Member Reviewing History

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (12 YRS AND UP)

Do you have any concerns about your mouth, teeth, or oral health? ☐ YES ☐ NO If YES, describe _____

Have you recently experienced any dental/oral pain? ☐ YES ☐ NO If YES, describe _____

Do you bleach your teeth? ☐ YES ☐ NO If YES, how often _____

Have there been any recent changes in your dietary habits? ☐ YES ☐ NO If YES, describe _____

Are you taking any dietary or herbal supplements? ☐ YES ☐ NO If YES, describe _____

Do you participate in contact sports or high speed sports (skiing, motorcycles)? ☐ YES ☐ NO If YES, describe _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.) ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.) ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

Eating disorder (anorexia, bulimia, etc.) ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

Oral piercings/jewelry (including grill) ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

Alcohol or recreational drug use/prescription abuse ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

Inhalant use/abuse (such as huffing) ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

Is there anything you would like to discuss confidentially with your dentist? ☐ YES ☐ NO

Would you like to discuss a referral to a family dentist or general dentist because of your age? ☐ YES ☐ NO

_____ _____

Signature of Mom, Dad or Legal Guardian (Circle one) Date Signature of Staff Member Reviewing History