Welcome to

NORWOOD PEDIATRIC DENTISTRY

ORAL HEALTH FORM

CHILD'S INFORMATION

CHILD'S NAME: FIRST LAST NICKNAME:

DATE OF BIRTH: GENDER: CELL PHONE:

ADDRESS: CITY: STATE: ZIP:

PARENT OR GUARDIAN NAME:

SCHOOL: GRADE:

SIBLINGS (NAMES & AGES):

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

PARENTS' INFORMATION:

PARENTS' MARITAL STATUS: ◯ MARRIED ◯ SINGLE ◯ OTHER RELATIONSHIP TO CHILD:

PARENT 1 NAME: FIRST LAST BIRTHDATE:

ADDRESS:

CELL NUMBER: WORK NUMBER: HOME NUMBER:

EMPLOYER: OCCUPATION:

EMAIL:

PARENT 2 NAME: FIRST LAST BIRTHDATE:

ADDRESS:

CELL NUMBER: WORK NUMBER: HOME NUMBER:

EMPLOYER: OCCUPATION:

EMAIL:

DENTAL INSURANCE INFORMATION:

PRIMARY INSURED NAME: GROUP POLICY NO: SOCIAL SECURITY NO: DOB:

INSURANCE COMPANY NAME: PHONE NO:

ANY SECONDARY INSURANCE:

CHILD'S MEDICAL HISTORY:

CHILD'S PHYSICIAN: DATE OF LAST VISIT:

NAME OF PRACTICE: PHONE NUMBER:

1. ARE IMMUNIZATIONS CURRENT? ◯ YES ◯ NO

2. IS YOUR CHILD UNDER MEDICAL CARE AT PRESENT? ◯ YES ◯ NO IF YES, PLEASE EXPLAIN:

3. HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS? PLEASE CHECK OFF ALL THAT APPLY:

☐ ADD/ADHD	☐ CHRONIC SINUS INFECTIONS	☐ HEART DISEASE	☐ RHEUMATIC FEVER
☐ ALLERGIES	☐ CHRONIC EAR INFECTIONS	☐ HEART MURMUR	☐ SICKLE CELL DISEASE
☐ ANEMIA	☐ CYSTIC FIBROSIS	☐ HEART DEFECTS	☐ SICKLE CELL TRAIT
☐ ANXIETY/DEPRESSION	☐ SEIZURES/EPILEPSY	☐ HEMOPHILIA	☐ TUBERCULOSIS
☐ ASTHMA	☐ DEVELOPMENTAL DELAY	☐ KIDNEY PROBLEMS	☐ NEUROLOGICAL PROBLEMS
☐ AUTISM/ASPERGER	☐ DIABETES	☐ LIVER PROBLEMS	☐ ORTHOPEDIC PROBLEMS
☐ BLEEDING DISORDERS	☐ DOWN SYNDROME	☐ LUNG PROBLEMS	☐ EYE PROBLEMS
☐ CANCERS	☐ HIV/AIDS	☐ PSYCHIATRIC TREATMENTS	☐ ACID REFLUX
☐ CEREBRAL PALSY	☐ HEPATITIS	☐ SPEECH/HEARING PROBLEMS	☐ EMOTIONAL DISTURBANCES
☐ CLEFT LIP/PALATE	☐ MENTAL RETARDATION	☐ BIRTH DEFECTS	
☐ HIGH BLOOD PRESSURE	☐ LEARNING DISABILITIES	☐ PREMATURE BIRTH	

4. DOES YOUR CHILD HAVE ANY OTHER DISEASES, CONDITIONS, OR SYNDROMES NOT LISTED ABOVE? ◯ YES ◯ NO

IF YES TO #3 or #4, PLEASE EXPLAIN FURTHER:

(CONTINUED ON REVERSE)

5. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? ◯ YES ◯ NO

LIST ALL FOOD & DRUG ALLERGIES:

6. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? ◯ YES ◯ NO

IF YES, PLEASE LIST:

7. HAS YOUR CHILD EVER BEEN SEDATED OR HAD GENERAL ANESTHESIA? ◯ YES ◯ NO

IF YES, WHAT FOR?

8. HAS YOUR CHILD EVER HAD SURGERY OR BEEN HOSPITALIZED? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN:

9. IS YOUR CHILD HAVING ANY DIFFICULTIES IN SCHOOL? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN:

10. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD?

11. IS THERE ANYTHING ABOUT YOUR CHILD YOU WOULD LIKE TO DISCUSS IN PRIVATE? ◯ YES ◯ NO

DENTAL HISTORY:

1. PLEASE CHECK OFF REASON(S) FOR SEEKING DENTAL CARE:

☐ FIRST EXAMINATION ☐ ROUTINE CHECK-UP ☐ TOOTHACHE OR SWELLING ☐ CAVITIES

☐ APPEARANCE OF TEETH ☐ CROWDING ☐ ACCIDENT/INJURY

OTHER:

2. HAS YOUR CHILD BEEN TO A DENTIST PREVIOUSLY? ◯ YES ◯ NO WHEN: WHERE:

3. WERE X-RAYS TAKEN: ◯ YES ◯ NO ◯ NOT SURE IF YES, WHEN:

4. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

☐ THUMB/FINGER SUCKING ☐ MOUTH BREATHING ☐ PACIFIER ☐ SNORING

☐ BOTTLE/SIPPY CUP ☐ LIP SUCKING/BITING ☐ GRINDING/CLENCHING

5. WHAT SOURCE OF WATER DOES YOUR CHILD DRINK: ◯ CITY WATER ◯ BOTTLED WATER ◯ WELL WATER

6. IS YOUR CHILD BREAST FED OR FORMULA FED? IF NO, WHAT AGE DID IT STOP?

WHAT TYPE OF DRINKS DOES YOUR CHILD CONSUME (CHECK ALL THAT APPLY) ☐ JUICE ☐ SPORTS DRINKS ☐ SODA ☐ OTHER:

7. FREQUENCY OF TOOTH BRUSHING? FLOSSING?

8. WHO DOES THE BRUSHING? (CHECK ALL THAT APPLY) ☐ CHILD ☐ PARENT/GUARDIAN

9. WHAT TYPE OF TOOTHPASTE DOES YOUR CHILD USE: ◯ FLUORIDE ◯ NO FLUORIDE

10. HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT? (CHECK ALL THAT APPLY)

☐ OUTGOING ☐ SHY ☐ STUBBORN ☐ ANXIOUS ☐ FRIGHTENED ☐ REGULAR KID

☐ CURIOUS ☐ MOODY ☐ FRIENDLY ☐ DEFIANT ☐ HIGH STRUNG ☐ COOPERATIVE

11. HAS YOUR CHILD EVER EXPERIENCED ANY PROBLEMS OR COMPLICATIONS DUE TO DENTAL CARE? ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN:

CONSENT:

THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZE NORWOOD PEDIATRIC DENTISTRY TO COMPLETE **A DENTAL EVALUATION, INCLUDING EXAMINATION, X-RAYS, PHOTOGRAPHS, CLEANING AND FLUORIDE TREATMENT** WHEN NECESSARY AS STANDARD OF CARE TO PROPERLY DIAGNOSE AND RECORD ANY AND ALL DENTAL CONDITIONS. TO UTILIZE BEHAVIOR MANAGEMENT THERAPY AS NEEDED TO PROVIDE SAFE DENTAL CARE FOR YOUR CHILD AND TO EMPLOY SUCH ASSISTANCE AS IS APPROPRIATE. **PLEASE CROSS OUT ANY TREATMENT THAT YOU DO NOT WANT PERFORMED.**
I AUTHORIZE MY INSURANCE COMPANY TO PAY NORWOOD PEDIATRIC DENTISTRY ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED WHETHER OR NOT IT IS COVERED BY MY INSURANCE, INCLUDING ALL LATE PAYMENT SERVICES CHARGES.
THIS CONSENT IS TO REMAIN IN EFFECT FROM THE DATE INDICATED UNTIL CANCELLED IN WRITING.

PLEASE ALSO LIST NAMES OF WHO YOU AUTHORIZE TO BRING YOUR CHILD FOR PLANNED TREATMENT:____________________________________.o

AUTHORIZED SIGNATURE______________________________ RELATIONSHIP TO CHILD______________________________ DATE_________

DOCTOR SIGNATURE____ DATE___________

OFFICE USE ONLY

SBE PROPHYLAXIS REQUIRED: ◯ YES ◯ NO **PRECAUTIONS:**

SUMMARY: