NORWOOD PEDIATRIC DENTISTRY

WELCOMES YOU

ORAL HEALTH FORM

We welcome your child into our practice and we will try to make his/her dental experience very pleasant. Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Child's Name _____

What is your child called (nickname) _____ Date of Birth _____ Current Weight _____

Name and Age of Brothers and Sisters _____

Child's Physician or Pediatrician _____

Physician's Phone _____ Family Dentist_____

Dental Insurance: Yes __ No __ Name of Insurance Company _____

Who may we thank for referring you to our office? _____

Name and kind of child's favorite pet toy, hobby or sport activity? _____

What is your chief complaint, if any, about your child's mouth or teeth? _____

_____

_____

HEALTH HISTORY

Does your child now have or has he or she ever had any of the following? (PLEASE CHECK)

__Anemia	__Chicken Pox	__Hepatitis	__Mental Retardation	__Tuberculosis
__Asthma	__Convulsions	__Kidney Disorders	__Mononucleosis	__Vision Disorders
__Bladder Disease	__Diabetes	__Liver Disease	__Mumps	__Blood Transfusions
__Blood Disorders	__Epilepsy	__Lung Disease	__Rheumatic Fever	__Other
__Bleeding Disorders	__Hearing Disorders	__Malignancies	__Sinus Problems	
__Cerebral Palsy	__Heart Disorders	__Measles	__Thyroid Disorders	

1. Is your child in good health? ☐Yes ☐No
2. Is your child under the care of a physician now? for illness or injury? ☐Yes ☐No
3. Has your child had an unexplained weight loss in the last 12 months? ☐Yes ☐No
4. Is your child taking any medicine or drugs? ☐Yes ☐No
   If so, what?_____
5. Does your child have any swollen glands or lymph nodes? ☐Yes ☐No
6. Is there excessive bleeding when cut? ☐Yes ☐No
7. Has your child ever been hospitalized? ☐Yes ☐No
8. Has your child ever had surgery? ☐Yes ☐No
9. Is there any allergy or unfavorable reaction to antibiotics (e.g. penicillin), local anesthetics or other drugs? If so, please specify _____ ☐Yes ☐No
10. Are there other allergies: food, pollen, animals, dust or other? ☐Yes ☐No
11. Current immunizations: __DPT #1 (2 mo.) __DPT #2 (4 mo.) __DPT #3 (6 mo.) __DPT #4 (15 mo.) __Polio (2 mo.) __Polio (18 mo.) __Measles, mumps, rubella (15 mo.) ☐Yes ☐No
12. Is there any other information I should be aware of that is not mentioned above? ☐Yes ☐No

Please describe:

_____

_____

_____

_____

(CONTINUED ON REVERSE)

DENTAL AND FAMILY HISTORY

Has your child any history of nail biting, thumb sucking, finger sucking, mouth breathing, teeth grinding or did he/she use a pacifier past age 11/2 years? (underline condition) __Yes __No
Is this a currently active habit?
Does your child have or has he/she had frequent ear and throat infections or tubes in ears? __Yes __No
Has your child any history of hearing loss or speech problems? (underline and explain) __Yes __No

Has mother or father had a lot of tooth decay? __Yes __No
In your family is there any history of malocclusions, bad bites, missing or extra teeth? (underline and explain)

Has your child had a toothache recently? __Yes __No
Is your child in pain now? __Yes __No
Do you think there is anything wrong with his/her teeth, such as a chipped or decayed tooth, gum boil, etc. Explain

Has your child had previous dental treatment? __Yes __No When and where? _____
Do mother and father and child live together? __Yes __No If no, please explain_____

Is your child adopted? __Yes __No
If you have previously completed this form for another child, please give that child's name_____

PREVENTIVE ASSESSMENT

Tooth Cleaning
Frequency: Times per day__ When?_____
Type of Toothbrush_____
Dental Floss ___Yes ___No
Disclosing Tablets ___Yes ___No
Who is responsible for tooth cleaning? __Parent __Child __Both
Have you received instruction in tooth cleaning? ___Yes ___No

Fluoride Inventory
Water fluoridation __Yes __No __Unsure
Fluoride Supplements __Yes __No
If Yes to above, what kind?_____
Fluoride RInse __Yes __No
Fluoride Toothpaste __Yes __No

Father/Guardian Name_____
Birthdate_____
Soc. Sec. #_____ Phone #_____
Home Address_____

Mother Name_____
Birthdate_____
Soc. Sec #_____ Phone #_____
Home Address_____

Mailing Address if different from home address_____

Father Employed by (if Self, state business name)_____ How Long?_____
Occupation_____
Business Address_____ Phone_____
street city state zip code

Mother Employed by_____ How Long?_____
Business Address_____ Phone_____
street city state zip code

In case of emergency - name of nearest relative or friend_____ Phone_____

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any/or all necessary dental treatment is performed.

Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered. Your signature authorizes the dentist to render necessary dental treatment, to administer anesthetics, to administer medications, to take radiographs (X-Rays). clinical photographs, study models and other records necessary for an accurate diagnosis, to utilize behavior management therapy as needed to provide safe dental care for your child and to employ such assistance as is appropriate.
The undersigned also agrees to be responsible for any bill incurred on this child for dental treatment.

Date_____ Parent Signature_____

Date_____ Dentist Signature_____