Sunnyside Dentistry for Children, PC

CHILD'S FULL NAME_____**PREFERRED NAME**_____ **Sex:** _____ **DOB**_____

Parent/Guardian/Responsible Party Information:

PARENT/GUARDIAN	**PARENT/GUARDIAN**
FIRST/LAST NAME_____	FIRST/LAST NAME_____
Sex: _____ DOB_____ SSN_____-____-_____	Sex: _____ DOB_____ SSN_____-____-_____
Relationship to child: _____	Relationship to child: _____
Mailing Address: _____	Mailing Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____-_____-_____	Home Phone: _____-_____-_____
Cell Phone: _____-_____-_____	Cell Phone: _____-_____-_____
Email: _____@_____	Email: _____@_____
Employer: _____	Employer: _____
Work Phone: _____-_____-_____	Work Phone: _____-_____-_____
Marital Status:	Marital Status:
Married / Single / Separated / Divorced / Widow	Married / Single / Separated / Divorced / Widow

Preferred Method of Communication for Appointment Reminders

e-mail reminders to_____ Text Reminders to _____-_____-_____

DENTAL

1. How does your child receive fluoride? ☐WATER ☐ SUPPLEMENT ☐ TOOTHPASTE ☐ RINSE ☐NO FLUORIDE
2. Has your child ever seen an orthodontist? ☐YES ☐ NO Orthodontist's Name: _____
3. Is your child currently in braces? ☐YES ☐ NO
4. Does your child: BRUSH REGULARLY ☐YES ☐ NO USE DENTAL FLOSS REGULARLY ☐YES ☐ NO

NEW PATIENTS ONLY

(IF THIS IS YOUR FIRST VISIT WITH OUR OFFICE, PLEASE COMPLETE THE FOLLOWING DENTAL HISTORY)

1. Is this your child's first dental visit? ☐YES ☐ NO Previous Dentist/Visit Date: _____
2. What is your reason for bringing your child to the dentist today? _____
3. Has your child had any unfavorable medical or dental experiences? ☐YES ☐ NO

Please explain: _____

4. Does your child currently have or have a history of any of the following? *(circle if any apply)*

Cavities	Extracted Teeth	Thumb Sucking	Teeth grinding	Toothache
Gum Infection	Nail biting	Broken Teeth	Mouth Injury	Lip sucking
Pacifier use	Finger Sucking	Prolonged bottle/breast feeding		

MEDICAL HISTORY AND HEALTH QUESTIONNAIRE *(PLEASE ANSWER ALL QUESTIONS)*

1. Child's physician/clinic:_____ Phone:_____
2. Date of last physical exam:_____ Findings?_____
3. Is your child presently under a physican's care for a condition? ☐YES ☐ NO If YES: What? _____
4. Has your child had any surgeries? ☐YES ☐ NO If Yes: Surgery & Dates _____
5. Has your child ever been hospitalized for more than 24 hours? ☐YES ☐ NO If yes: Why & Dates _____
6. Is your child currently taking any medications? ☐YES ☐ NO *please list medications*

   Medication:_____ Dosage:_____ Reason?_____

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   Medication:_____ Dosage:_____ Reason?_____

7. Does you child have any of the following allergies? *(circle all that apply or mark NO ALLERGIES)* **☐NO ALLERGIES**

AMOXICIILIN	CODEINE	LATEX	PENICILLIN
ANIMAL DANDER	EGGS	LOCAL ANESTHETIC	SEASONAL ALLERGIES
AUGMENTIN	GLUTEN	METAL	SULFA DRUGS
CLINDAMYCIN	HAY FEVER	NUTS (including tree nuts)	ZITHROMAX

OTHER (*please specify)* _____

8. Is your child current with immunizations? ☐YES, up to date w/ vaccinations ☐ Scheduled for updates ☐ NO
9. Was your child born with a heart defect? ☐YES ☐ NO If yes: Defect_____

   Was surgery required? ☐YES ☐ NO Date: _____ Pre-med Required ☐YES ☐ NO

DOES YOUR CHILD HAVE A HISTORY OF (*circle all that apply or mark NONE APPLY)*

ACID REFLUX/GERD	CONGENITAL BIRTH DEFECTS	EPILEPSY	RECURRENT HEADACHES/MIGRAINES
ADD/ADHD	CONVULSIONS/SEIZURES	HEARING DIFFICULTIES	RHEUMATIC FEVER
AIDS	DENTAL ANXIETY	HEART CONDITIONS	SPEECH IMPEDIMENT
ANEMIA	DIABETES	HIV	THYROID DISORDER
ASTHMA	DIGESTIVE SYSTEM DISORDER	INTELLECTUAL DISABILITY	TMJ DIFFICULTIES
AUTISM	DOWN SYNDROME	JAUNDICE (other than newborn)	TUBERCULOSIS
AUTOIMMUNE DISEASE	EATING DISORDER	LACTOSE INTOLLERANT	TUMORS/CANCER
BACTERIAL/VIRAL INFECTION	EMOTIONAL/ANXIETY	LEARNING DIFFICULTIES	**☐NONE APPLY**
BEHAVIOR DIFFICULTIES	ENDOCRINE SYSTEM DISORDER	LIVER DISEASE	
BREATHING DIFFICULTIES	EYE/SIGHT DIFFICULTIES (not incl. glasses)	LUNG DISEASE	
BLOOD DISEASE	EXCESSIVE BLEEDING	MOOD DISORDER	
BLOOD TRANSFUSION: Y/N	DATE: _____		

11. Are there any medical or psychological issues or disabilities not listed above? _____

_____

INFORMED CONSENT

THE PERMISSION OF PARENT OR GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR.

I give the doctors permission to use such measures as deemed necessary in their professional judgement to render the diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollens, dust, latex, including skin reactions, abnormal bleeding or any other condition related to my child's health or any other physical condition that my child's medical doctor has advised me should be reported to a dentist.

Signature: _____ Relationship to child_____ Date_____

Reviewed by staff member or doctor: _____ Date_____