

# Sunnyside Dentistry for Children - David E. Doyle, DDS

**CHILD'S FULL NAME** \_\_\_\_\_ **PREFERRED NAME** \_\_\_\_\_ Sex: \_\_\_\_\_ **DOB** \_\_\_\_\_

### **Parent/Guardian/Responsible Party Information:**

<b>PARENT/GUARDIAN</b>	<b>PARENT/GUARDIAN</b>
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: Married / Single / Separated / Divorced / Widow	Marital Status: 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 physician'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? \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason? \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason? \_\_\_\_\_

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

- |               |           |                            |                    |
|---------------|-----------|----------------------------|--------------------|
| AMOXICILIN    | 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         | <input type="checkbox"/> <b>NONE APPLY</b> |
| 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** \_\_\_\_\_