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CHILDREN & TEEN DENTAL
pediatric dentistry & orthodontics

# NEW PATIENT QUESTIONNAIRE & CONSENT

## I. GENERAL INFORMATION

Residence Address Street _____ Home Phone _____
City _____ State _____ Zip Code _____
Father's Full Name _____ Social Sec # _____-_____-_____
Father's Date of Birth _____ Cell Phone # _____
Employed By _____ Work Phone _____
Mother's Full Name _____ Social Sec # _____-_____-_____
Mother's Date of Birth _____ Cell Phone # _____
Employed By _____ Work Phone _____

## II. CHILD'S HISTORY

Child's Full Name _____ Social Sec # _____-_____-_____
Name Child Goes By _____ Age _____ Date of Birth _____
Place of Birth _____ Attends what school? _____
Names & Ages of Brothers and Sisters _____

## III. MEDICAL HISTORY (Circle all appropriate conditions)

1. Has your child ever experienced any of the following:

| | | |
|---|---|---|
| a. | Seizures loss of consciousness, fainting, Cerebral Palsy, trauma to the head, or developmental delay? | Yes No |
| b. | Heart Disease, Rheumatic Fever, Prolonged Bleeding or any Blood Dyscrasias or Disease, or Heart Murmur? | Yes No |
| c. | Shortness of Breath, difficulty in breathing, Pneumonia or any chronic infection of the respiratory tract (Bronchitis or Asthma)? | Yes No |
| d. | Liver Disease, Jaundice or any Malabsorption Syndrome? | Yes No |
| e. | Kidney or Bladder Disease? | Yes No |
| f. | Diabetes or Glandular problems? | Yes No |
| g. | Allergies or any unfavorable reaction(s) to any medicines such as: Penicillin, Aspirin, local anesthetic, & etc. Please list: _____ | Yes No |
| h. | Latex Allergy? | Yes No |
| i. | Hepatitis? | Yes No |
| j. | HIV (AIDS)? | Yes No |

2. Has this patient had a blood transfusion? ___Yes ___No If so, when? _____
3. Has this patient seen a physician (Medical Doctor) in the last six months? ___Yes ___No
   If so, why? _____
4. Is your child taking any medication(s) at this time? ___Yes ___No If so, what? _____
5. Has your child ever had a serious illness or operation? ___ Yes ___No If so, what? _____
   _____
6. Has your child ever been hospitalized? ___Yes ___No For what? _____
7. Has your child had a physical exam within the last year? ___Yes ___No
8. Are there any medical problems or other medical information you feel we need to know? ___Yes ___No If so, what? _____
9. Name of Child's Physician/Address/Phone # _____
10. Is your child: ___Advanced ___Progressing Normally ___A Slow Learner ___Hyperactive

Email Address (confirm appts, reminders,etc.) _____

Patient's Last & First Name: _____, _____ Date of Birth: _____

**IV. DENTAL HISTORY**

| | | |
|---|---|---|
| 1. | Who is your family dentist? | |
| 2. | Is this your child's first visit to the dentist? | Yes No |
| 3. | Has your child had a toothache recently? | Yes No |
| 4. | Has your child ever fallen and chipped or damaged any of his/her teeth? | Yes No |
| 5. | Is there a history of oral habits (thumb-sucking, lip or nail biting)? | Yes No |
| 6. | Do you rate your child's oral hygiene habits as being poor? | Yes No |

**V. PAYMENT PLAN: (Please Check)**

Cash _____ Check _____ Charge Card _____ Insurance _____ Medicaid_____ Other _____

**VI. CONSENT**

Your child is a minor, therefore it is necessary that a signed permission be obtained from a parent or guardian before any necessary dental service can be stated. I grant J. Barry Burgess, DMD or Richard A Simpson, DMD permission to provide my child's dental exam and treatment and I will be responsible for the cost of this dental care.

Signed by _____ Date _____

Parent or Guardian (Please circle) Driver's License#/State ___ _____

## PAST DENTAL HISTORY

Child's Name _____ Age _____

Yes___ No___ Any current Toothaches or Pain?
Yes___ No___ Any history of loss of sleep due to tooth or gum discomfort?
Yes___ No___ Any history of pain with eating?
Yes___ No___ Taking any pain medication?

First Dental Visit: Age ____ Dentist _____ Type of Treatment _____

Last Dental Exam: Age ____ Dentist _____ Type of Treatment _____

Last X-Rays: _____ Last Topical Fluoride Treatment _____

Oral Hygiene: Who brushes child's teeth? _____ When? _____
Toothpaste brand: _____ Do you floss your child's teeth? ___Yes ___No
If so, how often? ___Daily ___Weekly ___Other

Fluoride History: Home water source— City ___ Well___ Other _____
Does your child take Fluoride supplements? Yes ____ No ____
If so, what? _____
Does your child use Fluoride rinses or gels? Yes ____ No ____
If so, what? _____

Has your child ever had any difficulty, problems, or bad experiences with past dental care?
Please explain: _____

How did you hear about our office/Who referred you? _____