WABAN DENTAL GROUP

PEDIATRIC MEDICAL AND DENTAL HISTORY

Child's Name: _____ Middle Initial: ____ Today's Date: _____

(First) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Nick Name (s) : _____ Gender: Male ___ Female ___

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Preferred Communication for Appointment Reminders: ___Text Message ___E: Mail ___Phone ___ Do Not Call

Parent/Guardian:_____ Occupation: _____

Employer: _____ Work Phone: _____ Extension: _____

Parent/Guardian: _____ Occupation: _____

Employer:_____ Work Phone:_____ Extension: _____

Referred By: _____ Names & ages of siblings:_____

Billing Information

Guarantor: _____ DOB: _____ SS#: _____

Address: _____

Dental Insurance Information

If your child is covered by dental insurance, please complete the following insurance information
Payment at the time of service may be requested if insurance information is incomplete.

Primary Dental Insurance

Subscriber Name: _____ Subscriber DOB: _____

Insurance Carrier: _____ Subscriber #: _____ Group Number:_____

Insurance Billing Address: _____

Secondary Dental Insurance

Subscriber Name: _____ Subscriber DOB: _____

Insurance Carrier: _____ Subscriber #: _____ Group Number:_____

Insurance Billing Address: _____

MEDICAL HISTORY

Child's Physician _____ Phone # _____

Address _____ City, State _____

Date of Last Physical Examination _____

Is your child being treated by a physician at this time? ..... YES NO

If yes, why? _____

Is your child taking any medications at this time? ..... YES NO

If yes, what and why? _____

Has your child ever been hospitalized? ..... YES NO

If yes, why and when? _____

Has your child had any operations? ..... YES NO

If yes, why and when? _____

Has your child ever had general anesthesia? ..... YES NO

If yes, were there any complications? _____

Is your child allergic to anything? (Medications, Food) ..... YES NO

If yes, what? _____

Has your child ever been given penicillin? ..... YES NO

If yes, were there any complications? _____

Is your child up to date on his/her immunizations? ..... YES NO

Mother's decay experience ..... HIGH MODERATE LOW

Organs and Systems: Has your child ever had any treatment for any of the following? Please check yes or no:

YES	NO		YES	NO	
_____	_____	Blood - Circulatory	_____	_____	Heart
_____	_____	Bones	_____	_____	Liver
_____	_____	Endocrine Glands	_____	_____	Muscles
_____	_____	Eyes, Ears, Nose, Throat	_____	_____	Nervous System
_____	_____	Gastrointestinal (stomach)	_____	_____	Skin Eczema
_____	_____	Kidney - Bladder	_____	_____	Tonsils/Adenoids

If yes to any of the above, please elaborate.

Illness: Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

YES	NO		YES	NO	
_____	_____	Anemia	_____	_____	Heart Disease
_____	_____	Allergy	_____	_____	Heart Murmur
_____	_____	Arthritis	_____	_____	Hemophilia
_____	_____	Asthma	_____	_____	Hepatitis - Type _____
_____	_____	Autism	_____	_____	Immune Deficiency
_____	_____	Brain Injury	_____	_____	Jaundice
_____	_____	Cancer	_____	_____	Learning Disabilities
_____	_____	Cerebral Palsy	_____	_____	Leukemia
_____	_____	Chicken Pox	_____	_____	Mental Retardation
_____	_____	Cleft lip/Palate	_____	_____	Nutritional Deficiency
_____	_____	Convulsions/Seizures	_____	_____	Orthopedic Problems
_____	_____	Diabetes	_____	_____	Rheumatic Fever
_____	_____	Emotional Disturbance	_____	_____	Scoliosis
_____	_____	Epilepsy	_____	_____	Sickle Cell Anemia
_____	_____	Eye Problems	_____	_____	Spina Bifida
_____	_____	Excessive Bleeding Problem	_____	_____	Tetanus
_____	_____	Fainting	_____	_____	Whooping Cough
_____	_____	Hearing Loss	_____	_____	Other _____

DENTAL HISTORY

Is this your child's first dental visit? ..... YES NO

Reason for bringing child for this visit? _____

_____

Name of child's previous dentist: _____ Date of last visit _____

Has your child had dental radiographs (x-rays)? ..... YES NO

If yes, where were they last taken? _____

Has your child ever had local anesthesia? (Novacaine) ..... YES NO

If yes, were there any complications? _____

Please indicate if your child has or has had any of the following oral habits:

Snoring ..... YES NO

Breathes through mouth ..... YES NO

Sucks thumb or finger ..... YES NO If yes, until what age? _____

Uses a pacifier ..... YES NO If yes, until what age? _____

Bites or sucks lips ..... YES NO

Tongue habit ..... YES NO

Bottle to bed ..... YES NO If yes, until what age? _____

Other _____

Do you live in a community with fluoridated water? ..... YES NO

Does your child drink tap water? ..... YES NO Approximate amount: _____

Do you have a water filter? ..... YES NO Type: _____

Does your child use any fluoride supplements? (Rinses, vitamins) YES NO

If yes, name of product? _____ YES NO

How often does your child brush his/her teeth? _____

When? _____

Brand of toothpaste? _____

Type of toothbrush? Hard _____ Soft _____

Does your child floss his/her teeth? ..... YES NO

When? _____

Is there parental assistance or supervision when:

Brushing? ..... YES NO

Flossing? ..... YES NO

Additional Remarks: _____

THE SIGNATURE OF A PARENT OR GUARDIAN BELOW AUTHORIZES THE COMPLETION OF ALL AGREED UPON NECESSARY DENTAL SERVICES.

SIGNATURE _____

DATE _____

RELATIONSHIP _____

Please bring this completed form to your child's initial appointment.

TO BE COMPLETED BY REVIEWER:

Medical History Summary:
(Precautions, medical entities, SBE)

Dental History Summary:
(Previous experience, OHI, F1 Hx)

Reviewer _____ Date _____

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE (√)	CHANGES	PARENT INITIAL

WDG 1117