PARK PEDIATRIC DENTISTRY
of Woodstock

Patient Information

Today's Date _____/_____/_____

Patient: LAST FIRST INITIAL	Nickname	Date of Birth / /
Address STREET CITY STATE ZIP CODE		
Phone HOME	CHILD'S SOC SEC #	Sex: M ☐ F ☐
SCHOOL	GRADE	HOBBIES
Child primarily lives with	Person financially responsible	
How did you hear about our practice?		
Father: ☐ Stepfather ☐ Guardian Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ LAST FIRST INITIAL	E-Mail	
Address (If Different from Above) STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		
Employer	Date of Birth / /	Driver's License #
Mother: ☐ Stepmother ☐ Guardian Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ LAST FIRST INITIAL	E-Mail	
Address (If Different from Above) STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		
Employer	Date of Birth / /	Driver's License #
Who should we contact regarding your child's appointment?		
How would you prefer to be contacted? ☐ E-Mail ☐ Text ☐ Home Phone ☐ Cell Phone		
Insurance Information: Policy Holder	SS#	Date of Birth / /
Employer	Relationship to Patient	
Insurance Company	Group Number	Policy Number
Mailing Address	Phone Number	
Emergency Contact: LAST FIRST	Relationship to Patient	
Address STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		

PARK PEDIATRIC DENTISTRY of Woodstock

Dental History

Patient: Age

LAST FIRST INITIAL NICKNAME

Dental History Phone Number

Previous Dentist

Date of Last Dental Visit: / /

Date of Last Cleaning: / /

Date of Last X-Rays: / /

Do you have a copy of your child's previous x-rays? ☐ YES ☐ NO

Has your child been to an orthodontist for an evaluation? ☐ YES ☐ NO Name Phone Number

Is there a family history of orthodontics? ☐ YES ☐ NO If so, who?

Does your child have a history of unfavorable reactions to the dentist? ☐ YES ☐ NO

If yes, explain:

My child brushes _____ times per day.

My child flosses every day: ☐ YES ☐ NO

Who flosses for child? ☐ Child ☐ Parent

Is tooth brushing supervised? ☐ YES ☐ NO

Sleep Disordered Breathing

Is there a family history of wearing a sleep appliance, TMJ appliance, or mouth guard? ☐ YES ☐ NO If so, who? _____

Is there a history of:

Mouth Breathing	☐ YES ☐ NO	Adenoid/Tonsil Removal	☐ YES ☐ NO	Difficulty Sleeping	☐ YES ☐ NO
Grinding	☐ YES ☐ NO	Heavy Breathing	☐ YES ☐ NO	Speech Problems	☐ YES ☐ NO
Snoring	☐ YES ☐ NO	Bed Wetting	☐ YES ☐ NO	Tongue Thrust	☐ YES ☐ NO

Does your child:

☐ Use a Pacifier If so, how often? _____

☐ Suck Thumb/Fingers If so, how often? _____

☐ Sleep with Bottle/Sippy Cup If so, how often? _____

For children under 5, was/is your child: ☐ Breast-Fed ☐ Bottle-Fed

Today's Visit

Reason for today's visit:

Is your child experiencing any dental pain? ☐ YES ☐ NO

If yes, explain:

Does your child have a specific dental problem that needs attention? ☐ YES ☐ NO

If yes, explain:

Pharmacy Phone Number

Pharmacy Name Location

Consent for Treatment

To the best of my knowledge, the information given herein is accurate and complete. It is my responsibility to inform Park Pediatric Dentistry of Woodstock of any changes in my child's medical or dental status.

I am the parent or legal guardian of _____ and there are no court orders in
Name of Minor/Child

place that prohibit me from signing this consent. I do hereby request and authorize Dr. Park and/or his staff to perform necessary dental procedures for the child named above.

All procedures will be discussed, and a separate consent obtained, prior to any dental treatment.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Print Name of Parent or Legal Guardian Relationship to Patient

PARK PEDIATRIC DENTISTRY of Woodstock

Medical History

Patient: LAST FIRST INITIAL NICKNAME	Age
Medical Information Child's Pediatrician	Phone Number

Date of Last Physical: / /	Are your child's immunizations up to date? ☐ YES ☐ NO	Current Physical Health: ☐ Excellent ☐ Fair ☐ Poor

Is child currently under the care of a physician? ☐ YES ☐ NO
If yes, explain:

Has your child ever been hospitalized, sedated, or had surgery? ☐ YES ☐ NO
If yes, explain:

Has your child ever had a serious head, mouth, or neck injury? ☐ YES ☐ NO
If yes, explain:

Is your child taking any medications? ☐ YES ☐ NO
List:

Is your child on a special diet? ☐ YES ☐ NO
Type:

Does your child have any allergies to medicines, latex, food, or metals? ☐ YES ☐ NO
List:

Are antibiotics necessary for dental work due to a heart murmur, heart defect, prosthesis, shunt, or other reason? ☐ YES ☐ NO
If yes, explain:

Has any member of the family, including your child, had a problem with sedation or general anesthesia? ☐ YES ☐ NO
If yes, explain:

Does your child have any handicaps or disabilities? ☐ YES ☐ NO
If yes, explain:

Medical History

Please check "Y" for Yes or "N" for No if your child has had any history of, or conditions relating to, any of the following:

☐ Y ☐ N Abnormal Bleeding	☐ Y ☐ N Cleft Palate/Lip	☐ Y ☐ N Growth Problems/Delays	☐ Y ☐ N Lung Disease
☐ Y ☐ N ADD/ADHD	☐ Y ☐ N Cold Sores/Fever Blisters	☐ Y ☐ N Hayfever/Allergies	☐ Y ☐ N Measles
☐ Y ☐ N AIDS/HIV+	☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Hearing Impairment	☐ Y ☐ N Mononucleosis
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Convulsions	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Mumps
☐ Y ☐ N Anemia	☐ Y ☐ N Cortisone Medicine	If yes, is Heart Murmur innocent?	☐ Y ☐ N Pain in Jaw Joints
☐ Y ☐ N Asthma	☐ Y ☐ N Diabetes	☐ Yes ☐ No	☐ Y ☐ N Pregnancy
☐ Y ☐ N Autism	☐ Y ☐ N Down Syndrome	☐ Y ☐ N Heart Trouble/Disease	☐ Y ☐ N Premature Birth
☐ Y ☐ N Behavioral Problems	☐ Y ☐ N Drug/Alcohol Abuse	☐ Y ☐ N Hemophilia	☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Birth Defects	☐ Y ☐ N Earaches/Ear Infections	☐ Y ☐ N Hepatitis	☐ Y ☐ N Recent Weight Loss
☐ Y ☐ N Bladder Problems	☐ Y ☐ N Easily Winded	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Blood Disease	☐ Y ☐ N Eating Disorder	☐ Y ☐ N Hives/Rash	☐ Y ☐ N Sickle Cell Dises
☐ Y ☐ N Blood Transfusions	☐ Y ☐ N Epilepsy/Seizures	☐ Y ☐ N Hypoglycemia	☐ Y ☐ N Sinus Problems
☐ Y ☐ N Brain Injury	☐ Y ☐ N Excessive Bleeding	☐ Y ☐ N Irregular Heart Beat	☐ Y ☐ N Sleep Apnea
☐ Y ☐ N Breathing Problem	☐ Y ☐ N Excessive Thirst	☐ Y ☐ N Kidney Problems	☐ Y ☐ N Speech Impairment
☐ Y ☐ N Bruise Easily	☐ Y ☐ N Fainting/Dizziness	☐ Y ☐ N Learning Disabilities	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Cancer/Tumor	☐ Y ☐ N Frequent Cough	☐ Y ☐ N Leukemia	☐ Y ☐ N Stomach Problems
☐ Y ☐ N Cerebral Palsy	☐ Y ☐ N Frequent Diarrhea	☐ Y ☐ N Liver Disease	☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Chicken Pox	☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Tuberculosis

Is there any other health information that should be known? ☐ YES ☐ NO

If yes, explain:

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information is dangerous to my child's health. It is my responsibility to inform Park Pediatric Dentistry of any changes to my child's medical status.

Signature of Parent/Guardian _____ Date _____