

RETURNING PATIENT FORM

Patient Name (First and Last Name): _____ DOB: _____

Phone: _____ 2nd Phone: _____ Email: _____

Any changes to home address? If yes, please list new address below:

Do you have a new dental insurance? If yes, please list Name and ID # below:

Please check any dental concerns:

- | | | | | |
|--|---|--|---|-------------------------------------|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Color of Teeth | <input type="checkbox"/> Grinding of Teeth | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Jaw Sounds |
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Toothache | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Dental Pain | <input type="checkbox"/> None | <input type="checkbox"/> Other: _____ | | |

Medical and Dental History

Yes No When was your child's last dental visit? Date of last cleaning & x-rays (if taken) _____

Yes No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain:

Yes No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? _____

Yes No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? _____

Yes No Does your child snack frequently? What are their favorite snack foods? _____

Yes No Has your child had local anesthetic? If yes, were there any problems? _____

Yes No Has your child ever been sedated for dental treatment? If yes were there any problems? _____

Yes No Have your child's teeth ever been injured? Which teeth: _____

Yes No Does your child have a cold sore or other mouth ulcer? Please describe: _____

Yes No Does your child use a fluoride toothpaste?

Yes No Does your child begin to smoke cigarettes or use any tobacco products?

Yes No Is your child in good health? Date of last physical exam: _____

Yes No Has your child ever had a health problem? _____

Yes No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:

Yes No Is your child currently taking any medications? Please give medication, dose, and reason:

Yes No Are your child's immunizations current?

Yes No Have you ever been told that your child needs to take antibiotics before dental treatment?

Please check if your child has been treated for any of the following:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Cancers/Tumors | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Significant Injuries |
| <input type="checkbox"/> Adverse Drug Reaction | <input type="checkbox"/> Congenital Birth Defect | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver/GI Disease | <input type="checkbox"/> Speech/Hearing Issues |
| <input type="checkbox"/> Asthma/Breathing Problems | <input type="checkbox"/> Endocrine/Growth Problems | <input type="checkbox"/> Mental Delays | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eyesight Problems | <input type="checkbox"/> Personality Problems | <input type="checkbox"/> Tonsil Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

Does your child have any allergies?

Medication(s) Latex Anesthetics Bisphosphonate Food

Please specify: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Parent/Guardian Name & Signature: _____ Date: _____