Little Pearls Kids Dentistry & Orthodontics

Patient Information

Patient's Full Name:_____ Nickname/Preferred Name_____

DOB:_____ Gender: **M/F** Address:_____
City:_____ZipCode:_____Phone:_____

How did you hear about our office:_____

Insurance Subscriber:

First Name:_____ Last Name:_____ DOB:_____

SSN#:_____ (**Required**) Employer:_____

Relationship toPatient:_____Home/CellPhone:_____

Email:_____

Guardian #2:

First Name:_____ Last Name:_____ DOB:_____
SSN#_____ Phone:_____Relationship to Patient:_____

Emergency Contact:_____ (Other than parent)Relationship:_____

Insurance

Dental Insurance
Company:_____ID#:_____
Group #:_____Phone #:_____

Dental History

Is this the patient's first visit to a dentist? **Y/N**

Has patient been seen by a dentist regularly? **Y/N** Last Visit:_____

Dentist Name:_____ Phone:_____

Has the patient had any dental treatment in the past? **Y/N** Type:_____

Has the patient ever had a difficult experience at a dental visit:_____

Has the patient had any injuries to face/mouth/ or teeth?: **Y/N** Please explain:_____

_____

Has the patient ever sucked fingers and/or thumb?: **Y/N** Does the patient have any speech disorders?: **Y/N** Is Patient a mouth breather?: **Y/N** While **AWAKE** or **ASLEEP** (Please circle)

Does the patient have any popping/clicking/or discomfort when opening or closing his/her mouth**?: Y/N** Is your drinking water fluoridated?: **Y/N** Is patient taking a fluoride supplement? **Y/N** If so what type (e.g. tablets/rinse):_____

How often are teeth brushed?:_____ Flossed?:_____ By Whom?:_____

Medical History

Physician:_____ Phone #:_____

Patients Current Weight:_____ Height:_____ Is patient in good health?: **Y/N** Is patient currently under the care of their physician? **Y/N** If yes, for what condition?_____ Does patient need any pre-medication/antibiotic prior to dental treatment? **Y/N** Does patient have any history of major illness?: **Y/N** If yes, when:_____ Has the patient ever been hospitalized: **Y/N** If yes, for what?_____

Is the patient taking any medications at this time?: **Y/N** If yes, please list medications_____

Does the patient have any of the following frequently?: (IF YES PLEASE CIRCLE)

COLDS / EAR INFECTIONS / SORE THROAT/ SINUS CONGESTIONS / BREATHING PROBLEMS

Any other conditions not previously listed for which the patient has been treated:_____Does the patient have any allergies or drug sensitivities: **Y/N** If yes, please list_____
Has the patient had tonsils and/or adenoids removed?: **Y/N** If yes, when?:_____

Do you authorize any other adult guardian to accompany your child to their dental visits on your behalf?

Name:_____ Relationship:_____

Parent/Guardian Name:_____ **Signature**:_____

Dentist Signature:_____ **Date**:_____