Today's Date_____

Portsmouth Pediatric Dentistry Patient Information

Child' s Name _____ Date of Birth _____
First Middle Int. Last

Nick Name_____ School Grade _____

Address _____ Home Phone _____

City _____ Male _____ Female_____

State & Zip_____ Cell Number(s) _____

Mother's Name _____ Soc. Security No _____

Address _____ Occupation _____

_____ Employer _____

Email _____ Business Phone _____

Father's Name_____ Soc. Security No. _____

Address _____ Occupation _____

_____ Employer _____

Email _____ Business Phone _____

Child's Physician _____ Telephone_____

Street and City_____ State & Zip _____

Family Dentist _____

Do you give us permission to contact you through email/ text message to confirm appointments? _____Yes _____No

Whom may we thank for referring you?_____

Dental Insurance Information

Insurance Company, Address, & Phone _____

Subscriber's Name _____ Policy and/or Group# _____

Subscriber's Employer _____ Subscriber's ID# and DOB _____

Parent Responsibilities

I understand that I am responsible to pay for services rendered to my child at the time of service, unless other arrangements have been made.

Signature of Parent / Responsible Party:_____Date:_____

(PLEASE TURN OVER)

Medical History

Were there any difficulties during pregnancy, delivery, or first year of life? ____ Yes ____ No
If yes, please explain_____

Nursing/ bottle/sippy cup/ pacifier past or present? ____ Yes ____ No
Is a physician treating your child presently for a specific illness? ____ Yes ____ No
Is your child taking any medications at this time ? ____ Yes ____ No

Drug	Dose	Frequency	Reason

Is your child up to date on all of his/her immunizations? ____ Yes ____ No
Has your child taken any unusual medications in the past? _____ ____ Yes ____ No
Has your child had any allergic or unusual reactions to medications or food ?_____ ____ Yes ____ No
Has your child ever been hospitalized or had any operations? ____ Yes ____ No
If so, when and for what reason?_____
Approximate weight of your child_____LBS

__ADD or PDD
__Down Syndrome
__Rheumatic Fever
__Hearing Problems
__Kidney Disease
__Latex Allergy
__Bleeding Disorders
__Diabetes
__Anemia
__Asthma
__Speech Problems
__Vision Problems
__Sensory Problems
__Anxiety
__Liver Disease
__Emotional Problems
__Sickle Cell Disease
__Heart Murmur/Defect
__Tuberculosis
__Learning Problems
__AIDS/HIV
__Seizures
__Cystic Fibrosis
__Bleeding Disorder
__Cerebral Palsy
__Autism

Does your child have any history of any of the following conditions ? Check if yes.

Adolescent Section (13 and older)

Although dental personnel treat the area in and around the mouth, the mouth is part of your entire body. Health conditions or medications that you may be taking could have an import interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is your child taking an oral contraception?____ Yes ____ No Is your child pregnant? ____ Yes ____ No
Does your child use tobacco?____ Yes ____ No

Dental History

Please check the reason(s) for seeking care at this time.

__First Dental Visit __Toothache/Swelling __Consult
__Accident __Appearance of Teeth __Check Up

If your child has been to a dentist previously, when was the visit? _____
Were X-Rays taken? ____ Yes ____ No
How did your child react?_____
Does your child take fluoride supplements? ____ Yes ____ No