Gentle Dental Patient Registration & Dental Health for Children

Date: _____

PATIENT

Patient Name	Age	Home Phone ☐ ( )	*Please check one box at left to show the preferred way to contact by phone*
Home Address	City, State, Zip	Parent Cell Phone ☐ ( )	
Email for confirming appointments		Parent Work Phone ☐ ( )	
Father's name _____ Mother's name _____		☐ Male ☐ Female	Birth date

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

RESPONSIBLE PARTY Relationship to Patient _____

Name	Social Security Number	Home Phone ☐ ( )	*Please check one box at left to show the preferred way to contact by phone*
Home Address	City, State, Zip	Cell Phone ☐ ( )	
Email Address		Work Phone ☐ ( )	
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	☐ Male ☐ Female Preferred Pronoun _____	Birth date	Drivers License and State
Responsible Person's Employer	Occupation		
Employer's Address	City, State, Zip		

SPOUSE OF RESPONSIBLE PARTY OR OTHER PARENT'S INFORMATION

Name	Social Security Number	Birth date	Home Phone ☐ ( )	*Please check one box at left to show the preferred way to contact by phone*
Employer	Occupation		Cell Phone ☐ ( )	
Employer Address	City, State, Zip		Work Phone ☐ ( )	

EMERGENCY CONTACT

Name	Relationship	Phone ( )
Name	Relationship	Phone ( )

If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____ *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration oflocal or topical anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____ _____

**Signature* *Date* *Relationship to Patient*

Terms and Conditions: This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above the conditions and agree to their content.

_____ _____

Signed *Date*

Patient Name _____ **Date of Birth** _____

Dental History (Please circle Y for yes or N for no.)

A. Y N Why have you brought your child to us today? (e.g.: pain, checkup/cleaning, etc.) _____

B. Y N Is this your child's first visit to the dentist? Previous Dentist _____
Last Visit _____ Date of last cleaning _____

C. Y N Reasons for changing dentists, if applicable: _____

D. Y N When was your/the parent's last visit to the dentist? _____

E. Y N Have you had any problems with past dental treatment? _____

F. Y N Is your child nervous or anxious about seeing a dentist? If yes please, tell us why: _____

G. Y N Has your child ever been sedated or had nitrous oxide (laughing gas) for dental treatment?
Please explain: _____

H. Y N Does your child require a "comfort item" for dental treatment (headphones, blanket, toy, etc.)?
Please describe: _____

I. Y N Does your child usually take antibiotics prior to dental treatment? Why? _____

J. Y N Does someone assist your child with tooth brushing? Who? _____

K. Y N Does your child brush? How often _____

L. Y N Does your child floss? How often _____

M. Y N Does your child use a power brush, water pik or power flosser? Which one? _____

N. Y N Does your child take fluoride drops, tablets or rinse? Which one? _____

O. Y N How often does your child eat sugary foods/drinks like sweets, pastries, cookies, juice, soda, etc.? (never, rarely, 1-2 times a week, daily, many times a day) _____

Oral Health (Please circle Y for yes or N for no.)

1. I consider my child's oral health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor If fair or poor, please describe:
_____
2. Y N Does your child have pain from his/her teeth or gums? Please describe: _____
3. Y N Has your child had a facial or jaw injury? Please describe: _____
4. Y N Does your child have problems eating? Please describe: _____
5. Y N Are your child's gums tender or swollen or do they bleed while brushing or flossing? _____
6. Y N Have you ever been told that your child has gingivitis? _____
7. Y N Are you happy with the appearance of your child's teeth? Why not? _____
8. Y N Are you satisfied with the way your child's teeth bite? Why not? _____
9. Y N Does your child suck his/her thumb, finger or pacifier/other object? _____
10. Y N Do you think that your child needs or will need braces? Why? _____
11. Y N Has your child had braces or used aligners to straighten his/her teeth? _____
12. Y N Does your child participate in any sports or similar activities? If yes, please list: _____
13. Y N Does your child wear a night guard, sports guard or similar device to protect his/her teeth? _____
14. Y N Does your child clench or grind his/her teeth during the day or while sleeping? _____
15. Y N Does your child have jaw pain, clicking or popping when opening his/her mouth? _____
16. Y N Does your child have excessive gagging, snoring, mouth breathing, or sleep apnea? _____
17. Y N Does your child suffer from insomnia or have other sleep disturbances? _____
18. What are your priorities for your child's oral health? (e.g.: appearance, dental health, financial considerations, etc.) _____
_____
_____
_____

Gentle Dental Patient Medical History for Children

Patient Name _____ **Date of Birth** _____

General Health

1. I consider my child's general health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor If fair or poor, please describe: _____

2. Y N Is your child being treated by a physician at this time? Reason: _____

3. Child's Height: _____ Child's Weight: _____

Does your child have or has he/she had any of the following? Please circle Y for yes or N for no.

4. High Risk for Bacterial Endocarditis
   - a. Y N Artificial (prosthetic) heart valve**
   - b. Y N Previous infective endocarditis (heart infection)**
   - c. Y N Damaged valves in transplanted heart **
   - d. Congenital heart disease (CHD):
     - Y N Unrepaired cyanotic CHD, including shunts and conduits (blood bypassing the lungs) **
     - Y N CHD, repaired (completely) in last 6 months**
     - Y N CHD, repaired with residual defects**

*** Except for these conditions, antibiotic prophylaxis is no longer recommended for any other form of heart disease or CHD*

5. Y N Cardiovascular Diseases? If yes, please answer Y/N for questions 5a-5d below:
   - a. Y N Heart disease Please describe: _____
   - b. Y N Heart valve problem/heart murmur/mitral valve prolapse/rheumatic fever, congenital heart disease/lesions
   - c. Y N Heart arrhythmia
   - d. Y N Abnormal blood pressure High or Low? _____ Typical blood pressure: _____

6. Y N Respiratory Diseases? If yes please answer Y/N for questions 6a-6e below:
   - a. Y N Asthma, reactive airway disease, wheezing, or breathing problems Please describe: _____
   - b. Y N Tuberculosis
   - c. Y N Lung disease, pneumonia, bronchitis Please describe: _____
   - d. Y N Sinusitis, chronic adenoid/tonsil infections
   - e. Y N Hay fever

7. Y N Diabetes/Endocrine Diseases? If yes, please answer Y/N for questions 7a-7e below:
   - a. Y N Diabetes Type _____ The most recent "A1c" was _____ Date: _____
   - b. Y N Take insulin/medications for diabetes If so, please provide name: _____
   - c. Y N Are blood sugar measurements taken? How often: _____
   - d. Y N Excessive urination and/or thirst
   - e. Y N Thyroid disease or pituitary disease Please describe: _____

8. Y N Other Important Diseases and Conditions?
   - a. Y N Arthritis? Please indicate type (osteoarthritis, rheumatoid, etc.): _____
   - b. Y N Implants/artificial joints: Hip-Knee _____ Other _____
   - c. Y N Trauma – head, neck or body? Please describe: _____
   - d. Y N Organ transplant/donor. Which organ? _____ When? _____
   - e. Y N Cancer, tumor or malignancy Please describe: _____
   - f. Y N Chemotherapy/radiation therapy
   - g. Y N Anemia, sickle cell disease/trait, or blood disorder. Please describe: _____
   - h. Y N Hemophilia, bruising easily, or excessive bleeding
   - i. Y N Herpes/apthous ulcers
   - j. Y N HIV/AIDS
   - k. Y N Immune disorder Please describe:_____
   - l. Y N Recurrent or frequent headaches/migraines, fainting, or dizziness Please describe: _____
   - m. Y N Fainting, loss of consciousness or dizziness Please describe: _____
   - n. Y N Cerebral palsy, brain injury, epilepsy, or convulsions/seizures Please describe: _____
   - o. Y N Has your child taken opiates/narcotics to manage pain? Last date taken: _____

Doctor Notes Only:

Patient Name _____ **Date of Birth** _____

9. Y N Behavioral, emotional, communication, or psychiatric problems/treatment? If yes, please answer Y/N for questions 9a-9f below:
   a. Please describe: _____
      Treatment received/medications: _____
   b. Y N Autism/Autism spectrum disorder/Asperger's syndrome
   c. Y N Sensory processing disorder
   d. Y N Attention deficit/hyperactivity disorder (ADD/ADHD)
   e. Y N Depression/anxiety
   f. Y N Impaired vision, visual processing, hearing, or speech

10. Y N Has your child had major surgery or hospitalizations?
    Year _____ Type of operation _____
    Year _____ Type of operation _____
    Year _____ Type of operation _____
    Year _____ Type of operation _____

11. Y N Is there anything else of a medical or behavioral nature you would like us to know about your child? _____
    _____

12. Is your child allergic to any of the following?
    a. Y N Local Anesthetics (i.e., Novocaine, Lidocaine)
    b. Y N Penicillin
    c. Y N Other antibiotics _____
    d. Y N Latex
    e. Y N Aspirin (Excedrin, Bayer, etc.)
    f. Y N Ibuprofen (Advil, Motrin, etc.)
    g. Y N Acetaminophen (Tylenol, etc.)
    h. Y N Sulfa drugs/Sulfites/Sulfides
    i. Y N Codeine
    j. Y N Metals, plastics
    k. Y N Dyes or artificial coloring
    l. Y N Milk or milk products
    m. Y N Iodine, iodine-based antiseptics, shellfish or radiologic dyes. Which ones? _____
    n. Y N Pine nuts, colophony, peanuts, other nuts? Which ones? _____
    o. Y N Other allergies. Which ones? _____

13. Please list all medications your child is currently taking (or submit list of medications):
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

14. Physician's Name _____ Phone _____ Date of last visit _____

    Address _____ Fax _____

15. Name of nearest relative not living with child _____ Phone _____

Initial medical/dental reviewed by:

(If patient is a minor, guardian's signature is required)

X _____ _____ X _____ _____
Doctor's Signature *Date* *Parent/Guardian's Signature* *Date*

Periodic medical/dental reviewed by:

X _____ _____ X _____ _____
Doctor's Signature *Date* *Parent/Guardian's Signature* *Date*

X _____ _____ X _____ _____
Doctor's Signature *Date* *Parent/Guardian's Signature* *Date*

X _____ _____ X _____ _____
Doctor's Signature *Date* *Parent/Guardian's Signature* *Date*

Doctor Notes Only: