SOFT SHORES
Pediatric Dentistry

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www.softshorespediatricdentistry.com

PATIENT INFORMATION DATE:_____

Last Name_____ First Name_____ Middle I____ Gender_____

Prefers to be addressed by _____ Date of Birth_____/_____/_____ Age _____

Address_____ Apt #_____

City _____ State_____ Zip _____ Home Telephone _____

Emergency Contact Name _____ Telephone* _____

Other family members treated at this office _____

PARENTAL INFORMATION

Mother

Name_____

Date of Birth _____/_____/_____

Social Security # _____

Cell phone# _____

Email _____

Single _____ Married _____ Widowed _____

Separated _____ Divorced _____ Guardian _____

Employer_____

Address_____

Telephone _____

Complete if DIFFERENT

Home Address_____

City _____ State _____ Zip _____

Home Telephone _____

Father

Name_____

Date of Birth _____/_____/_____

Social Security # _____

Cell phone# _____

Email _____

Single _____ Married _____ Widowed _____

Separated _____ Divorced _____ Guardian _____

Employer_____

Address_____

Telephone _____

Complete if DIFFERENT from patient's home

Home Address_____

City _____ State _____ Zip _____

Home Telephone _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Company_____

Address _____

City _____ State _____ Zip _____

Insurance Telephone _____

Policy/Group #_____

Policy Holder _____

Relationship to Patient _____

Secondary Insurance

Company_____

Address _____

City _____ State _____ Zip _____

Insurance Telephone _____

Policy/Group #_____

Policy Holder _____

Relationship to Patient _____

REFERRAL INFORMATION

How did you hear about our office?

PATIENT'S Name_____ D.O.B._____

Dental History

Previous dentist (if any) _____ Date of last dental exam _____

What concerns you most about your child's dental health?_____

Does your child have dental pain? Y_____ N_____ Level of pain (1-10)_____

Mouth habits? (Please check) Thumb sucking _____ Pacifier _____ Mouth Breather _____

Still on bottle _____ Finger habit _____ Tooth grinding _____ None _____

Has your child had a negative dental experience in the past? _____

If yes, please explain_____

How often does your child brush? _____ Floss? _____

Has your child received fluoride supplements? Y_____ N _____ If yes, what kind? _____

Are you happy with the appearance of your child's teeth? _____

Medical History

Name/Practice Name of child's pediatrician _____ Phone _____

Is your child under the care of a physician at this time? Y _____ N _____

Explain _____

Has your child ever had a serious illness or been hospitalized? Y_____ N _____ Date _____

Explain _____

Has your child ever had general anesthesia? Y _____ N _____

Explain _____

Are all your child's immunizations current? Y _____ N _____

Has your child ever been advised to take an antibiotic prior to any dental treatments? Y _____ N _____

If yes, antibiotic name and method _____

Is your child taking any medication? Y _____ N _____ If yes, what?_____

Does your child have allergies? (medications, food, latex, seasonal, etc.) Y _____ N _____

If yes, what? _____

Please answer the following. Has your child ever had a history of:

Y	N		Y	N	
☐	☐	ADD/ADHD	☐	☐	Heart Condition (type _____)
☐	☐	AIDS or H.I.V. Positive	☐	☐	Heart Murmur
☐	☐	Anemia	☐	☐	Heart Pacemaker
☐	☐	Artificial Heart Valve	☐	☐	Heart Surgery (date _____)
☐	☐	Asthma	☐	☐	Hemophilia (type _____)
☐	☐	Autism	☐	☐	Hepatitis (type _____)
☐	☐	Birth defects	☐	☐	Jaw Pain
☐	☐	Blood Disorders/Bleeding problems	☐	☐	Kidney Trouble
☐	☐	Brain Injury	☐	☐	Leukemia
☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Cerebral Palsy	☐	☐	Psychiatric Treatment
☐	☐	Cleft lip/Palate	☐	☐	Respiratory Lung Disease
☐	☐	Developmental Delayed	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Scoliosis
☐	☐	Earaches	☐	☐	Sickle Cell
☐	☐	Emotional Problems	☐	☐	Speech Problems
☐	☐	Epilepsy (seizures)	☐	☐	Syndrome (type _____)
☐	☐	Fainting Spells	☐	☐	Tonsillitis
☐	☐	Headaches	☐	☐	Tuberculosis
☐	☐	Hearing/Sight Impaired	☐	☐	Ulcers

☐ **Other:** _____

Is there any other information that we should know about your child's health? _____

I certify that the information given is correct and give consent to Soft Shores Pediatric Dentistry to treat my child.

Signature _____ Date _____

(Please circle one) Parent Guardian Other

Reviewed by _____

Date _____

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