pediatric dental at Bridgeport

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Although dentistry deals with primarily teeth and its surroundings structures, oral cavity is a part of the entire body. Health problems that your child may have, or medications that the child may be taking could have an important interaction with the dentistry your child will receive. Thank you for answering the following questions thoroughly.

Patient's Name _____ Birth date___/___/___Age____ Male/Female

Medical History

Yes No Any problems/complications during pregnancy/delivery?_____
Yes No Does your child have any health problems? _____
Yes No Has your child been diagnosed with any medical conditions?_____
Yes No Has your child ever been hospitalized? (For & When)_____
Yes No Has your child ever had surgery? (For & When) _____
Yes No Is your child taking any medications? (List)_____
Yes No Is your child allergic to any medication/food/latex? (List)_____
Yes No Is your child's immunizations up to date?_____
Name of Pediatrician _____ Name of Previous Dentist_____

Check any of the following conditions for which the patient has been treated:

( )ADHD/ADD
( ) Asthma
( ) Autism/ASD/Aspergers
( ) Blood Problems
( ) Bronchitis
( ) Cancer
( ) Cerebral Palsy
( ) Diabetes
( ) Down Syndrome
( ) Ear Infection
( ) Emotional Problems
( ) Endocrine Problems
( ) Epilepsy/ Seizures
( ) Eye Problems
( ) Hearing Problems
( ) Heart Problems
( ) Hepatitis A/B/C
( ) Liver/ Kidney Disease
( ) Leukemia
( ) Nutritional Problems
( ) Prolonged Bleeding
( ) Rheumatic Fever
( ) Speech Problems
( ) Tonsillitis
( ) Tuberculosis
( ) Thyroid Disease

Dental History

Main reason for today's visit?_____

How often are the child's teeth brushed? ( )1X/day ( )2X/day ( ) Every other day ( ) Not Regularly
How often are the child's teeth being flossed? ( )1X/day ( ) Every other day ( ) 1X/week ( ) Not Regularly
Who does the brushing/ flossing? ( ) Parent ( ) Child ( ) Half & Half ( ) None
Fluoride use: ( ) Rx by MD/DMD ( ) In H_2O ( ) Toothpaste ( ) Fluoride Rinse ( ) None
When was the child weaned off nursing/ bottle? ( ) 6 month ( ) 12 month ( ) 24 month ( )Still Use
Does the child have any oral habits? ( ) Thumb/finger ( ) Binky ( ) Mouth breather ( ) Grinding
History of dental trauma: Yes No If yes please explain:_____
How would you rate the mother's oral health? ( ) Excellent ( ) Good ( ) Fair ( ) Poor ( ) Don't Know
How would you rate the father's oral health? ( ) Excellent ( ) Good ( ) Fair ( ) Poor ( ) Don 't Know
How would you rate the child's sugar consumption? (candy, juice, etc.) ( ) Low ( ) Average ( ) High
Is there any additional medical/ dental information that you may want your dentist to know?

_____
_____
_____

Parent/ Guardian Signature_____ Relationship to the patient_____ Date___/___/___