pediatric dental at Bridgeport

Ben Kang DMD,MS,PC
Board Certified Pediatric Dentist

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 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)_____
Name of Pediatrician _____

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?_____
Has your child been seen by a dentist prior to our office? Yes No
If yes, roughly how long ago? _____Name of the previous dentist:_____
Any information about the child behavior at previous office: _____
_____
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
How would you rate the child's sugar consumption? (candy, soda, sports drinks) ( ) Low ( ) Average ( ) High
History of dental trauma: Yes No If yes, please explain:_____
_____
History of Jaw Pain: Yes No If yes, Please explain:_____
_____
Do you or your child have any questions regarding need for braces? Yes No
Do you or your child have any questions regarding the color/shade of his/her teeth? Yes No
Does your child participate in contact sports? Yes No If yes, does he/she use sports guard? Yes No
Is there any additional medical/ dental information that you may want your dentist to know?

_____
_____
_____

12+

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