pediatric dental at Bridgeport

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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 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 _____

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

Who does the brushing/ flossing? ( ) Parent ( ) Child ( ) Half & Half ( ) None

Fluoride use: ( ) Rx by MD/DMD ( ) In H_2O ( ) Toothpaste ( ) Fluoride Rinse ( ) None

How would you rate the child's sugar consumption? (candy, juice) ( ) Low ( ) Average ( ) High

History of dental trauma: Yes No If yes, please explain:_____

History of Jaw Pain: Yes No If yes, Please explain:_____

Does the child have any oral habits? ( ) Thumb/finger ( ) Binky ( ) Mouth breather ( ) Grinding

Do you or your child have any questions regarding need for braces at this time? 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 or dental information that you may want your dentist to know?

_____

_____

_____

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