PATIENT REGISTRATION

Date_____

Patient Name_____ Date of Birth_____ Sex____
First Middle Last

Home Address_____ Telephone #(____)_____
Street City State Zip Code

Mailing Address_____
Name Address Telephone #

With whom does the child reside?____Father____Mother____Legal Guardian____Other(list relationship)_____

Name, Address and Telephone# of Legal Guardian_____

_____

E-Mail Address_____

Whom may we thank for referring you to our office?_____
Name Address Telephone #

List the names of other immediate family members who are patients at Park-West Pediatric Dental_____

_____

School Attending_____ Favorite interest/hobby_____

Nickname_____

In case of an emergency please list a contact person._____
Name Relationship Telephone #

PARENT/GUARDIAN INFORMATION

Father's Name_____
E-mail Address_____
Address (If different from patient)
_____
Telephone #_____ Cell #_____

Birthdate_____Social Security#_____
Employer_____Position_____
Work Telephone #_____
Do you have dental Ins. coverage for child? ☐ Yes ☐ No

Mother's Name_____
E-mail Address_____
Address (If different from patient)
_____
Telephone #_____ Cell #_____

Birthdate_____Social Security#_____
Employer_____Position_____
Work Telephone #_____
Do you have dental Ins. coverage for child? ☐Yes ☐ No

Parents' Marital Status: ____Married ____Divorced ____Single ____Widowed ____Separated

Stepmother's Name_____
E-mail Address_____
Address (If different from patient)
_____
Telephone #_____ Cell #_____

Birthdate_____Social Security#_____
Employer_____Position_____
Work Telephone #_____
Do you have dental Ins. coverage for child? ☐ Yes ☐ No

Stepfather's Name_____
E-mail Address_____
Address (If different from patient)
_____
Telephone #_____ Cell #_____

Birthdate_____Social Security#_____
Employer_____Position_____
Work Telephone #_____
Do you have dental Ins. coverage for child? ☐ Yes ☐ No

Patient Name_____

MEDICAL HISTORY

Child's physician_____Address_____Phone(____)_____
Date of last physical examination_____Results_____
Pharmacy name_____Pharmacy location _____Phone(____)_____

	YES	NO
Is child under the care of a physician?	☐	☐
Explain: _____		
Is child receiving any medications or drugs?	☐	☐
List and explain reason for taking: _____		
Has your child ever been hospitalized?	☐	☐
List reasons: _____		
Any excessive or prolonged bleeding when cut?	☐	☐
Has your child ever had surgery?	☐	☐
Explain: _____		
Is your child allergic to any of the following? Penicillin	☐	☐
Latex products	☐	☐
Local anesthetic	☐	☐
Other drugs(List)_____	☐	☐
Does your child have good physical coordination?	☐	☐
Are there any emotional problems?	☐	☐
Explain _____		
Does your child frequently encounter stressful situations at home or school?	☐	☐
Explain _____		

Please describe any current medical information we need to be aware of that has not been covered?
(such as pending surgeries, or recent injuries)_____

Check if child has any history or difficulty with any of the following.

____ADD (Attention Deficit Disorder)
____ADHD (Attention Deficit Hyperactive Disorder)
____AIDS (HIV)
____Anemia
____Arthritis
____Anorexia
____Asthma ____frequency of attacks ____ exercise induced
____Autism
____Bladder
____Blood pressure concerns
____Blood transfusion-Explain _____
____Bruises easily
____Chicken Pox
____Convulsions/Epilepsy/Seizures
____Depression
____Diabetes
____Fainting spells
____Hearing impaired
____Heart condition-Explain _____
____Hepatitis Type A B C Other_____
____Hives or skin rash
____Liver disease
____Malignancies
____Mastoid
____Measles
____Mononucleosis
____Mumps
____Nervousness
____Persistent cough or cough up blood
____Rheumatic fever
____Thyroid
____Tuberculosis
____Venereal disease
____Surgery or radiation treatment for tumor, growth or condition of the head or neck

Your child may require antibiotic prior to dental treatment.
May we request release of your child's medical records for our reference? ____YES ____ NO
I have completed the requested information on this form to the best of my knowledge.
Date_____Signature_____Relationship to child_____

Patient Name_____

DENTAL HISTORY

Patient Name_____

Most important dental concern_____

Date of last dental visit_____Type of service_____

	YES	NO
Has your child complained about dental problems? (Explain)	☐	☐
Any problem associated with previous dental treatment? (Explain)	☐	☐
Any unhappy dental experiences? (Explain)	☐	☐
Has your child had any injuries to the mouth, teeth or head? (Explain)	☐	☐

How would you describe your child's attitude toward dentistry?_____

Please check the following to indicate "Yes" regarding this patient.

___apthous ulcers frequent (canker sores)
___breath odor
___herpetic lesions frequent (cold sores)
___earaches
___headaches
___jaws make a clicking, grinding or popping noise
___neck pain
___orthodontic concerns (crooked teeth or bite)
___snore at night
___speech impaired/unusual speech habits
_____
___teeth grinding
___teeth clenching
___mouthbreathing
___nail biting
___lip biting or sucking
___nursing or bottle habit
___pacifier____frequent____occasionally
___self induced purging (bulimia)
___thumbsucking___frequent___occasionally
___finger sucking___frequent___occasionally
___smoking
___chewing tobacco
___frequent consumption of carbonated beverages
___strong gag reflex
___frequent vomiting

Fluoride/Decay Risk Assessment	**YES**	**NO**	**Unsure**	
Is fluoride taken in any form?	☐	☐	☐	Type and Dosage_____
Is fluoride in your water supply?	☐	☐	☐	Green Bay city water is fluoridated.
Number of days in daycare_____				
Daycare fluoride level_____				
Fluoride toothpaste/rinse used	☐	☐	☐	
History of decay in family?	☐	☐	☐	
Mother's side?	☐	☐	☐	
Father's side?	☐	☐	☐	
Brothers or Sisters with decay?	☐	☐	☐	
Does your child brush teeth daily?	☐	☐	☐	How many times each day?_____
Do you brush your child's teeth?	☐	☐	☐	
Do your child's teeth get flossed daily?	☐	☐	☐	How many times each week?_____
Do you floss your child's teeth?	☐	☐	☐	

How do you feel about preserving baby teeth?____Important ____Not important ____No opinion

Patient Name_____

Please complete this page if child is 18 months or younger

Birth History
Patient name_____ Date of Birth_____
Birth weight ____lbs. ____oz. Birth length ____inches
____Full term
____Premature ____weeks
____Normal delivery
____Caesarean section
____Forceps delivery
____Complications during delivery
Explain:_____
_____

Please check all that apply.

Feeding History
____Breast feeding
How long? ____years ____months
Schedule frequency_____
____on-demand feeding
____bedtime
____supplemental bottle Began when? ____months
____weaned ____months
____currently breast feeding When? _____
____Bottle feeding
____ready to feed formula
____formula reconstituted with water
average time of each feeding _____
____bedtime bottle Contents of bottle_____
____bottle is used as a pacifier Contents of bottle_____
____weaned from bottle ____months
____currently bottle feeding When? _____
____Pacifier When used? _____
____Thumbsucking When? _____
____Finger sucking When? _____

Maternal/Paternal History
Did you have a normal pregnancy? ____yes ____no
Did you experience any difficulties or complications during your pregnancy? ____yes ____no
Please explain:_____
_____
Did you experience any of the following during pregnancy?
____severe morning sickness
____physical trauma or injury
____medications taken Explain:_____
____illness (not including colds or flu)_____
____other _____

Did your infant experience any of the following during the first few weeks of life?
____jaundice ____breathing difficulties ____feeding difficulties ____high fevers ____serious illness
____intubation ____other_____