NEWBURYPORT Dental Associates PC
est. 1978

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Today's Date: _____

PEDIATRIC REGISTRATION & HISTORY FORM

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: _____

Address: _____

_____

Sex: ❑ M ❑ F Age: _____ Date of Birth: _____ / _____ / _____

PRIMARY CONTACT INFORMATION

Name: _____

Check primary #:

❑ Home Phone: _____

❑ Work Phone: _____

❑ Cell Phone: _____

Email: _____

INSURANCE INFORMATION

Subscriber Name: _____

Relationship to Patient: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

SS or ID#: _____ Date of Birth: ___ / ___ / ___

Insurance Name: _____

Please notify front desk if there is any additional coverage.

DENTAL HISTORY

Please check reason(s) for seeking dental care:

❑ First examination ❑ Toothache ❑ Accident ❑ Swelling
❑ Routine check-up ❑ Appearance of teeth or face ❑ Other: _____

Has your child ever been to a dentist? ❑ Y ❑ N If yes, when was his/her last visit? _____

How did your child react? _____

Have x-rays been taken? ❑ Y ❑ N If yes, when? Date: _____

Have your child's teeth ever been injured? ❑ Y ❑ N If yes, explain: _____

Has your child received any surgical treatment to the mouth? ❑ Y ❑ N If yes, explain: _____

NUTRITION

What do your child's snacks consist of?

_____

_____

Does your child use a baby bottle at bedtime? ❑ Y ❑ N

FLUORIDE

Has your child had fluoride in any of the following forms?

❑ Drinking water (community fluoridation)
❑ Topical application to teeth
❑ Toothpaste; brand: _____
❑ Systemic supplement

ORAL HYGIENE

Does your child brush his/her own teeth? ❑ Y ❑ N

How many times daily? _____

Do you assist in brushing your child's teeth? ❑ Y ❑ N

Does your child floss? ❑ Y ❑ N

HABITS

Does your child have any of the following habits?

❑ Lip sucking or biting ❑ Mouth breathing
❑ Pacifier ❑ Thumb or finger sucking
❑ Tongue thrusting

Patient Name: _____ **Date of Birth:** ____ / ____ / ____

MEDICAL HISTORY

Has your child been seen by a physician in the past 12 months? ❑ Yes ❑ No

If yes, for what reasons? _____

_____

Physician's name: _____ Phone number: _____

Has your child ever been hospitalized? ❑ Yes ❑ No If yes, when? _____

And for what reason? _____

Has your child had any history of the following diseases or conditions?

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Cancer
  - Type: _____
- ❑ Cerebral Palsy
- ❑ Diabetes
  - ❑ Type 1 ❑ Type 2
- ❑ Emotional Disability
  - Type: _____
- ❑ Epilepsy
- ❑ Fainting
- ❑ Growth Problems
- ❑ Hearing Difficulties
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ HIV +/AIDS
- ❑ Immune Deficiency
- ❑ Kidney Disease
- ❑ Learning Differences
  - Type: _____
- ❑ Liver Disease
- ❑ Measles
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Thyroid
- ❑ Tuberculosis

Is there is a disease or condition not listed above that you think we should know about? _____

_____

MEDICATIONS

Is your child taking any medications at this time? ❑ Yes ❑ No If yes, please list:

_____

_____

ALLERGIES

Has your child shown any allergies or unusual reactions? ❑ Yes ❑ No If yes, please check all that apply and explain:

- ❑ Medications or drugs: _____
- ❑ Foods: _____
- ❑ Latex, Rubber: _____
- ❑ Other: _____

Parent / Guardian signature: _____ Date: ____ / ____ / ____

Dentist signature: _____ Date: ____ / ____ / ____