KINGWOOD
pediatric
dentistry

Child's Full Name: _____ Nickname: _____
Sex: M F Date of Birth: ____/____/_____ Age: _____ Home Phone:_____Cell:_____
Address:_____ City:_____ Zip:_____
Name(s) of other children seen in this office:_____
Please list the child's hobbies / interests: _____
Whom may we thank for referring you? _____
Who is accompanying the child today? _____ Relation:_____

Parent/Legal Guardian Information

Parent's Marital Status: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Single

☐Mother ☐Step Mother ☐Guardian

Name: _____ Driver's License #: _____State_____
Date of Birth: _____ Social Security #: _____
Address: _____
Home Phone #: (_____)_____ Work Phone #: (_____)_____
Cell / Mobile / Pager / Other Phone #(_____)_____ Email:_____
Dental Insurance: Yes___ No___ Company_____
Employer: _____

☐Father ☐Step Father ☐Guardian

Name: _____ Driver's License #: _____State_____
Date of Birth: _____ Social Security #: _____
Address: _____
Home Phone #: (_____)_____ Work Phone #: (_____)_____
Cell / Mobile / Pager / Other Phone #(_____)_____ Email:_____
Dental Insurance: Yes___ No___ Company_____
Employer: _____

Emergency Contact

His / Her Name: _____ Relation: _____
Work Phone #: (_____)_____ Home Phone #: (_____)_____
Cell / Mobil / Pager / Other Phone #(_____)_____
Address: _____

Medical History Child's

Physician:_____ Phone #: (____)_____ Date of last visit _____

Is the child currently under the care of a physician? ☐Yes ☐No
If yes, please explain:_____
Please describe the child's current physical health: ☐Good ☐Fair ☐Poor
Are Immunizations Current? ☐Yes ☐No
Please list all medications that the child is currently taking: _____

Please list all medications / foods / other that cause the child allergic reactions: _____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding	Y N Cleft Palate / Lip	Y N Hepatitis Type ____
Y N AIDS/HIV+	Y N Diabetes	Y N High / Low Blood Pressure
Y N Anemia	Y N Epilepsy / Seizures	Y N Hives
Y N Any Hospital Stays/Surgeries	Y N Handicaps / Disabilities	Y N Kidney Problems
Y N Asthma	Y N Hearing / Speech	Y N Liver Problems
Y N Blood Transfusion	Y N Heart Disease	Y N Rheumatic Fever
Y N Cancer	Y N Heart Murmur	Y N Sickle Cell Anemia
Y N Cerebral Palsy	Y N Hemophilia Type ____	Y N Tuberculosis (TB)

Please discuss the above and any other medical problems the child has / had: _____
_____

Dental History

What is the primary reason for today's visit? _____

Is your child currently having problems with any of the following?

☐Cavities ☐Toothache ☐Sensitive ☐Teeth Trauma
☐Gum Infection ☐Color of Teeth ☐Tooth Alignment ☐Other _____

Has the child experienced problems with previous dental work? ☐Yes ☐No
Explain_____
Is the child's home water supply fluoridated? ☐Yes ☐No
Does the child brush his / her teeth daily with fluoride toothpaste? ☐Yes ☐No
Do you give the child any other form of fluoride? ☐Yes ☐No If yes, what? _____
Does the child floss his / her teeth daily? ☐Yes ☐No
Was your child bottle / breastfed? What age was it completely stopped? _____
Does your child suck a finger / thumb / pacifier / or exhibit any other habits? _____
Previous/Present (circle) Dentist: _____ Date of last Visit: _____
Why did you leave your last dentist? _____
What did you like most about any dentist you have seen?_____
Least?_____

Signature _____ Date _____

Relationship to Child _____