West Metro Pediatric Dentistry

Patient Registration and Dental/Medical History Form

This form must be completed by a legal guardian

Patient Information

Child's Full Name _____ Nickname _____Birth Date: _____ Gender:___M___F
Child Lives with ___Both Parents ___ Mother ___ Father ___ Other: _____
Siblings (Names and Ages) _____
School Name/City _____ School Grade _____

Legal Guardian #1 Information

____Mother ____Father ____Stepmother ____Stepfather ____Grandmother ____Grandfather ___Other: _____
Full Name (First) _____ (Middle) _____ (Last) _____Nickname _____
Street Address _____City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Best? _____
Email Address _____ Social Security Number_____ Birth Date _____
Place of Employment _____ Occupation _____

Legal Guardian #2 Information

____Mother ____Father ____Stepmother ____Stepfather ____Grandmother ____Grandfather ___Other: _____
Full Name (First) _____ (Middle) _____ (Last) _____Nickname _____
____Street Address same as Legal Guardian #1 (above)
Street Address _____City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Best? _____
Email Address _____ Social Security Number_____ Birth Date _____
Place of Employment _____ Occupation _____

Emergency Contact Information (Person other than legal guardians listed above)

Full Name _____Relationship _____
Home Phone_____ Cell Phone_____ Work Phone_____ Best? _____

Insurance Information

PRIMARY DENTAL: Subscriber _____ Subscriber ID Number _____ Group Number _____
Insurance Company Name _____ Insurance Company State_____ Phone Number_____
SECONDARY DENTAL: Subscriber _____ Subscriber ID Number _____ Group Number _____
Insurance Company Name _____ Insurance Company State_____ Phone Number_____
MEDICAL: Subscriber _____ Subscriber ID Number _____ Group Number _____
Insurance Company Name _____ Insurance Company State_____ Phone Number_____

How did you hear about us?

___Pediatrician: _____ ___ Insurance Website: _____ ___ Event: _____
___Dentist: _____ ___ Google Search:_____ ___ Patient Family*:_____
___School Visit: _____ ___ Online Review Site:_____ ___Walk by/Drive by
___Sibling is a patient here ___ Facebook: _____ ___Other: _____

**We give a referral thank you gift for each family referred, so be sure to list the family name that referred you!*

Dental History

Purpose of appointment & problems/concerns: _____
Date of Last visit _____ Previous Dentist _____ Family Dentist _____
Has your child complained of any dental pain? ___Yes ___No Explain:_____
Has your child had any unhappy dental experiences? ___Yes ___No Explain:_____
Has your child had any injuries to his/her mouth/teeth/head? ___Yes ___No Explain:_____
Does your child thumb/finger suck, nail bite, mouth breath, or snore? ___Yes ___No Explain:_____
Does your child nurse/use a bottle/sippy cup/pacifier? ___Yes ___No Explain:_____
Does your child have any unusual speech habits? ___Yes ___No Explain:_____
Does your child have any jaw issues (clicking/popping/pain)? ___Yes ___No Explain:_____
Does your child wear any orthodontic appliances? In the past? ___Yes ___No Explain:_____
Any other dental history you would like us to know?:_____

Dental Hygiene/Dietary History/Caries Risk Assessment Information

Do you assist your child with tooth brushing? ___Yes ___No
How many times per day does your child brush? _____
Does your child use a fluoridated toothpaste? ___Yes ___No
Do you assist your child with flossing? ___Yes ___No
How many times per week does your child floss? _____
Does your child eat sugary or sticky snacks between meals? ___Yes ___No
Does your child drink sugary drinks or milk between meals? ___Yes ___No
Does your child drink fluoridated water? ___Yes ___No
Does your child take fluoride supplements? ___Yes ___No Type: _____

Has anyone in your immediate family been diagnosed with dental decay in the last 12 months? ___Yes ___No *(Continued on 2nd page-→)*

Patient Name: _____

Medical History

Pediatric Office Name _____ Doctor's Name _____ Date Last Visit _____

Street Address _____ City _____State ___ Zip _____ Phone:_____

Is your child under a doctor's care for a specific reason? ___Yes ___No

Explain: _____

Is your child taking any medications (prescription or over the counter), vitamins, or dietary supplements? ___Yes ___No

Explain: _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ___Yes ___No

Explain: _____

Has your child ever had a reaction to or a problem with an anesthetic? ___Yes ___No

Explain: _____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? ___Yes ___No

Explain: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? ___Yes ___No

Explain: _____

Is your child up to date on immunizations against childhood diseases? ___Yes ___No

Explain: _____

Does your child require antibiotic pre-medication before dental treatment? ___Yes ___No

Explain: _____

Please mark any of the following that apply to your child. Please provide additional details below. _____*Check here if none apply*

__Abuse or Neglect
__Acid Reflux
__ADD
__ADHD
__Adenoid/Tonsil Infections
__Adenoid/Tonsil Removal
__Anemia
__Arthritis
__Asthma
__Autism
__Autism Spectrum Disorder
__Behavioral Problems/Treatment
__Birth Defects
__Birth Complications
__Bladder Infection
__Bladder Problems
__Bleeding Disorder
__Blood Disorder
__Bone Marrow Transplant
__Brain Injury
__Breathing Problems
__Cancer
__Cerebral Palsy
__Chemotherapy
__Chronic Sinus
__CMV
__Communication Problems/Treatment
__Convulsions/Seizures
__Congenital Heart Defect
__Cystic Fibrosis
__Diabetes
__Dietary Restrictions
__Developmental Disorders
__Eating Disorder
__Eczema
__Emotional Problems/Treatment
__Epilepsy
__Fainting/Dizziness
__Food Allergies
__Frequent Colds/Coughs
__GERD
__Growth & Development Issues
__Headaches (Frequent)
__Hearing Loss
__Heart Disease
__Heart Murmur
__Heart Valves
__Hemophilia
__Hepatitis A/B/C
__Herpes
__Hormonal Problems
__Hyperglycemia
__Hypoglycemia
__HIV/AIDs
__High Blood Pressure
__Impaired Hearing
__Impaired Speech
__Impaired Vision
__Intellectual Disability
__Intestinal Problems
__Jaundice
__Kidney Infection
__Kidney Problems
__Lactose Intolerance
__Learning Problems/Delays
__Liver Problems
__Measles
__Migraines
__Mononucleousis
__Mouth sores/ulcers
__MRSA
__Nutritional Deficiencies
__Organ Transplant
__Pituitary Problems
__Pneumonia
__Precocious Puberty
__Premature Birth
__Psychiatric Problems/Treatment
__Radiation
__Reactive Airway Disease
__Rheumatic Fever
__Rheumatoid Arthritis
__Scarlet Fever
__Scoliosis
__Sensory Integration Disorder
__Sexually Transmitted Disease (STD)
__Shunt __VA __VV __VP
__Sickle Cell Disease
__Skin Problems
__Sleep Apnea
__Stomach Ulcer
__Thyroid Problems
__Tobacco Smoke Exposure
__Tuberculosis
__Tumor
__Transfusions
__Weight issues/concerns
__Wheezing

Provide details here: _____

_____

Is there any other significant medical history pertaining to this child and/or his/her family that the dentist should be told? __Yes __No Explain:

_____

Is there any other information that we need to be aware of regarding your child that has not yet been covered in this form? __Yes __No Explain:

_____

I understand that the information given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's medical status, insurance, and contact information. I authorize Dr. Bryan Savage and Dr. LaShica Young to perform dental services, to administer any necessary anesthetics or sedatives, and to perform any added procedures which they may deem necessary to the welfare of the patient during the authorized dental services.

Printed Name: _____ Signature: _____ Date: _____

Information given is strictly confidential and will not be released to anyone without your written permission.