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-mild/mod/severe
- ☐ 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-Type:_____
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Chronic Sinus
- ☐ CMV
- ☐ Communication Problems/Treatment
- ☐ Convulsions/Seizures
- ☐ Congenital Heart Defect
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dietary Restrictions
- ☐ Developmental Disorders
- ☐ Down Syndrome
- ☐ 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-Type:_____
- ☐ 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 ____wks
- ☐ 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 his associates 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.