Patient Registration and Health History Form for Foothills Pediatric Dentistry

I. Social History

Child's First Name:_____ Middle Initial:____ Last Name:_____
Preferred Name:_____ Age:_____ Date of Birth:_____
Sex: □ Male □ Female Child's SSN: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Parent / Legal Guardian's Name: _____
Relation to Child: _____ Home Phone #: _____
Cell Phone #: _____ Email address: _____

Parent / Legal Guardian's Name: _____
Relation to Child: _____ Home Phone #: _____
Cell Phone #: _____ Email address: _____

Primary Contact: _____
Preferred Communication: □ Home □ Cell □ Email

Emergency Contact Name (other than parent): _____
Relation to Child: _____
Home Phone #: _____ Cell Phone #: _____

Child lives with (please check all that apply): □ Both parents □ Mother □ Father
□ Stepmother □ Stepfather □ Grandparent □ Other_____

Other children in the family:
1. Name: _____ Age: _____
2. Name: _____ Age: _____
3. Name: _____ Age: _____
4. Name: _____ Age: _____

How did you hear about our office?
□ Referred by Friend or Family – Name: _____
□ Referred by General Dentist – Name: _____
□ Referred by Pediatrician – Name: _____
□ Direct Mailers (postcard sent to home)
□ Referral Brochure Placed on Door
□ Website
□ Phone Book
□ Saw the Sign
□ Other_____

Primary Insurance Information

Name of Insured:_____ Relation to Child: □ Self □ Father □ Mother
Insured Social Security #:_____ Insured Date of Birth:_____
Employer:_____
Employer Address:_____
Insurance Company:_____
Insurance Company Address:_____

Secondary Insurance Information

Name of Insured:_____ Relation to Child: □ Self □ Father □ Mother
Insured Social Security #:_____ Insured Date of Birth:_____
Employer:_____
Employer Address:_____
Insurance Company:_____
Insurance Company Address:_____

Medicaid Information

Exact Spelling of Name on Card:_____
Medicaid ID #:_____

II. Dental History

What is the reason for your child's dental visit?
□ Routine Exam and Cleaning □ Cavities □ Toothache □ Trauma
□ Concern about appearance of teeth (ie, crowding, position, etc.)
□ Other_____

□ Yes □ No Has your child ever been to the dentist?
If yes, what was the name of his/her previous dentist? _____
If yes, what was the date of his/her last cleaning? _____
□ Yes □ No Has your child ever had a bad dental experience?
If yes, please explain: _____
□ Yes □ No Does your child go to bed with a bottle or sippy cup?
□ Yes □ No Is your child at least 2 years of age and still using a pacifier?
□ Yes □ No Does your child suck his/her thumb or fingers?
□ Yes □ No Does your child frequently get sugary drinks or snacks between meals?
If yes, please list his/her favorite drinks or snacks: _____
□ Yes □ No Has your child ever been sedated for dental treatment?
If yes, were there any problems? _____
□ Yes □ No Has your child ever received general anesthesia for dental treatment?
If yes, were there any problems? _____

□ Yes □ No Has any family member had a bad reaction to general anesthesia?
If yes, please explain: _____
□ Yes □ No Have your child's teeth ever been injured?
Is yes, please explain: _____
□ Yes □ No Does your child use fluoride toothpaste?

Which type of water does your child primarily drink?
□ Public/City Water □ Bottled Water □ Private Well

Please check any of the following other forms of fluoride that you give your child:
□ Fluoride Supplements □ Fluoride Rinse

III. Medical History

Child's Pediatrician/Physician: _____
Office Street Address: _____
City: _____ State: _____ Zip: _____
Office Phone #: _____ Office Fax #: _____

□ Yes □ No Is your child in good health? Date of last physical exam: _____
□ Yes □ No Does your child currently or has your child previously had any health problems?
If yes, please list: _____
□ Yes □ No Was your child born premature?
□ Yes □ No Were there any problems during pregnancy or at birth?
□ Yes □ No Is your child taking any medications?
If yes, please list medication and reason: _____
□ Yes □ No Is your child allergic to anything?
If yes, please list: _____
□ Yes □ No Are your child's immunizations up to date?
□ Yes □ No Has your child ever been hospitalized, had any surgeries, or had to go to the emergency room?
If yes, please explain: _____
□ Yes □ No Has your child received medical treatment within the last 6 months?
If yes, please explain: _____
□ Yes □ No Does your child have any hearing, sight or speech problems?
If yes, please explain: _____
□ Yes □ No Have your ever been told that your child needs to take antibiotics before dental treatment?
If yes, please explain:_____

Please check one of the following to describe how you consider your child to be:
□ Advanced in the learning process □ Progressing normally □ Slow in the learning process

Please check if your child has been diagnosed with or treated for any of the following:

- ☐ Hearing Problems
- ☐ Eye/Vision Problems
- ☐ Speech Problems
- ☐ Recurrent Ear Infections
- ☐ Tonsil/Adenoid Problems
- ☐ Cleft Lip/Palate
- ☐ Snoring
- ☐ Obstructive Sleep Apnea
- ☐ Congenital Heart Defect
- ☐ Endocarditis
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Sickle Cell Anemia
- ☐ Bleeding Disorder / Hemophilia
- ☐ Rheumatic Fever
- ☐ HIV/AIDS
- ☐ Hay Fever (Seasonal Allergies)
- ☐ Asthma
- ☐ Cystic Fibrosis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Gastrointestinal Problems
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Spina bifida
- ☐ Seizures
- ☐ ADD/ADHD
- ☐ Developmental Delay
- ☐ Arthritis
- ☐ Diabetes
- ☐ Cancer/Tumors
- ☐ Abuse
- ☐ Cold Sores
- ☐ Apthous Ulcers (Canker Sores)
- ☐ Syndrome _____
- ☐ Other_____

Health History Summary (To be completed by the Doctor or Team)

IV. Consent for Dental Treatment

I, _____, affirm that the above information is correct to the best of my knowledge. I understand that it is my responsibility to inform Foothills Pediatric Dentistry of any changes in my child's medical status.

I consent to the performance of a diagnostic exam, x-rays, cleaning, and fluoride treatment upon my child as deemed appropriate by Foothills Pediatric Dentistry.

Signature of Parent / Legal Guardian: _____
Date: _____