Little Pearls Dentistry for Children

We are honored that you have chosen our office for your child's dental care. We are committed to your child's health and well-being. Please fill out the following forms as thoroughly as possible so that we may best serve you and your child. Thank you.

Name of child ______________________________ Birthdate ____________________

Prefers to be called ______________________ Sex: M F Hobbies ______________________

Home address ____
Street City State Zip

Home phone __________________ Person responsible for account ______________________

Whom may we thank for referring you? ______________________________________
If not referred, how did you hear about us? ______________________________________
May we email you a picture of your child's visit with us? Y N

Father/Guardian name ____________________________________ Date of Birth ____________
Address (if different from patient) ____
Home phone (if different) __________________ Cell __________________ Work __________________
Best number to contact/confirm Home/Cell/Work Email ______________________________
Employer ____________________________________ SS# ______________________
Dental insurance ____

Mother/Guardian name ____________________________________ Date of Birth ____________
Address (if different from patient) ____
Home phone (if different) __________________ Cell __________________ Work __________________
Best number to contact/confirm Home/Cell/Work Email ______________________________
Employer ____________________________________ SS# ______________________
Dental insurance ____

Marital status of parent(s) Married Single Divorced Widowed

DENTAL HISTORY OF CHILD

Has your child ever been to a dentist? If so, when and where ______________________________

What is the primary reason for your visit? ______________________________________

What are your expectations of us? ____

Has your child ever had any upsetting dental experiences? ______________________________

How would you describe your child? Friendly Shy Nervous Scared Strong-willed

Who brushes/flosses your child's teeth? ________ Does your child take fluoride supplements? Y N

Does your child have any habits? Thumb Pacifier Grinding Nail biting Other

Is there anything else you would like us to know about your child? ______________________________
____

MEDICAL CONDITION/HISTORY

Physician's name____ Phone_____________ Fax______________

Is your child currently being treated for any condition? Y N

____

History of hospitalizations:____

Does your child have or ever had any of the following? Please place X and explain below

___ADD/ADHD
___Anemia
___Artificial joints
___Asthma
___Autism spectrum disorder
___Bleeding disorder/hemophilia
___Cancer/leukemia/tumors
___Cerebral palsy
___Cleft lip/cleft palate
___Developmental delay
___Diabetes
___Eating disorder
___Endocrine (glandular) disorder
___Epilepsy or other seizure disorder
___Gastrointestinal problems
___Hearing, speech, or vision impairment (circle)
___Heart defect, disease, or murmur
___ Hepatitis
___ High blood pressure
___ HIV/AIDS
___ Hydrocephalus
___ Kidney disorder
___ Latex allergy
___ Liver disorder
___ Lung disease
___ Reaction to medication
___ Rheumatic fever
___ Scarlet fever
___ Sensory disorder
___ Sickle cell disease/trait
___ Syndrome (specify) ___________________
___ Tuberculosis
___ Other ______________________________

____
____

Please list any current medications and dosage

____
____

Please list any allergies, including those to medications

____
____

Thank you for your assistance in the care of your child. Please inform us at subsequent visits of any changes to your child's medical history, including any medications or allergies

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I certify that I am the child's legal guardian.

Child's name____

Signature of Parent/Guardian____ Date ________________

OFFICE USE ONLY _____ Registration info reviewed _____Medical history reviewed