WELCOME TO PEDIATRIC DENTISTRY OF GLENS FALLS

PLEASE TAKE A MOMENT TO TELL US ABOUT YOUR CHILD

Child's Name ______________________________ Nickname ______________
(LAST) (FIRST) (MIDDLE INITIAL)

Age __________ Male ________ Female ________ Date of Birth ______/______/______
(MONTH) (DAY) (YEAR)

Patient's Address ____
(STREET) (CITY) (STATE) (ZIP)

With whom does the patient live? ______________________ Phone # ______________

What is the best way to reach you? ❑ Home ❑ Work ____________ ❑ Cell Phone ____________
❑ E-mail ______________________________

Please answer the questions by checking either YES or NO. If you are uncertain, leave it unanswered.

1. Is there any specific dental problem you wish to discuss with the doctor? ❑ YES ❑ NO
   If yes, please describe: ______________________________

2. Are you happy with your child's smile? ❑ YES ❑ NO
   If no, what is your concern? ______________________________

3. Which of the following would you like to learn more about? **(Please circle letter)**
   A. Thumb or finger sucking C. Sealants E. Braces G. Other ____________
   B. Bad Breath D. Teeth grinding F. Whitening

4. Has your child complained of any dental problems? ❑ YES ❑ NO
   A. If yes, for how long?: ______________________________
   B. If yes, please describe location of pain (i.e. top right, lower left, etc.) ____________

5. Has your child ever had an unpleasant dental experience? ❑ YES ❑ NO
   If yes, please describe: ______________________________

6. Has your child ever been under the care of a dentist? ❑ YES ❑ NO
   If yes, name of dentist and date of last visit ______________________________
   Please circle letter of type of care.
   A. Check up/cleaning C. Treatment (fillings, extractions)
   B. Emergency pain relief (toothache) D. Other; describe ____________

7. Does your child now take fluoride in any other form other than in toothpaste: ____________ ❑ YES ❑ NO
   If yes, circle type: Water Pill Liquid Vitamin

Did you know???

Whistle Toothbrush = Dentist Drill

Bumpy Brush = Dentist Drill

Sleepy Drops = Novocain administered with a needle

Wiggles = Extractions

Red Stuff = Blood

Tooth Counter = Explorer

Tickle = To clean the teeth

Tickle Toothbrush = Hygienists tooth brush

Mr. Thirsty = Suction instrument

Vacuum = Suction instrument

Tooth Pillow = Mouth Prop

Counting Teeth = Dr.'s Exam

Please remember, we DO NOT use terms such as Yank, Pull, Rip, Shots or Needles around children.

MEDICAL HISTORY

1. Is your child currently under a physician's care for any reason? ❑ YES ❑ NO
   If yes, please describe: ______________________________

2. Has your child ever been hospitalized? ❑ YES ❑ NO
   If yes, please describe: ______________________________

3. Has your child ever received a blood transfusion? ❑ YES ❑ NO
   If yes, please indicate date(s) and explain: ______________________________

4. Is your child currently taking any medication? ❑ YES ❑ NO
   If yes, please write name, dose and how often taken: ______________________________
   ____

5. Has your child ever had an unusual or allergic reaction to any of the following? **(Please Circle)**

Penicillin/Amoxicillin	Other antibiotics	Local Anesthetics (Novocain)
Aspirin	Codeine	Latex

   If yes, please describe: ______________________________

6. Is your child sensitive or allergic to anything else? (e.g., food, animals, bees, pollen, dust, etc.) ❑ YES ❑ NO
   If yes, please describe: ______________________________

7. Has your child ever been diagnosed with heart murmur? ______________ ❑ YES ❑ NO
   If yes, doctor's name ______________________________ Phone #: ______________

8. Has your child had any of the following? **(Please circle letter)**

A. ADD/ADHD	H. Convulsions (seizures)	O. Heart Disease	V. Rheumatic Fever
B. Anemia	I. Continuous Colds	P. Hepatitis (jaundice)	W. Scarlet Fever
C. Asthma	J. Diabetes	Q. Kidney Disease	X. Speech Problems
D. Autism	K. Downs Syndrome	R. Leukemia	Y. Thyroid Conditions
E. Bladder Problems	L. Epilepsy	S. Lung Disease	Z. Tuberculosis
F. Bleeding Problems	M. Fainting Spells	T. Mononucleosis	
G. Cancer	N. Hearing Problems	U. Pneumonia	

Please describe any that are circled (unless already mentioned elsewhere) ______________________________
____

Please describe any other medical problems not listed here: ______________________________
____

9. Young women (12 years and older) Is your daughter taking birth control? ❑ YES ❑ NO

10. Is your daughter pregnant? ❑ YES ❑ NO

Whom may we thank for referring you? ______________________________

I hereby certify that the information contained in these forms is accurate and complete to the best of my knowledge.

Signature ______________________________ Date ______________
(PARENT OR LEGAL GUARDIAN)

Relationship ______________________________

Is there any problem that you would like the doctor to look at or discuss today? ❒ YES ❒ NO
If yes, please describe ______________________________

Medical history changes ______________________________

Is your child currently taking any medications? ❒ YES ❒ NO
If yes, please write the name, dose and how often taken ______________________________

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