Pediatric Dentistry
Peter B. Geller, D.D.S.
David M. Petrarca, D.D.S., P.C.
Sungyon Bang, D.M.D.

Pediatric Dentistry
Donna M. Hackley, D.M.D.
Robert A. Frank, D.M.D.
Orthodontics
Sven Supplies, D.M.D.
Elizabeth C. Blake, D.M.D..

Children's Dental Associates
Dentistry and Orthodontics for Children and Young Adults

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Medford, MA 02155
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www.childrenzdentist.com

REVIEWED BY
Dr./Date

Pediatric Patient Information and Health History Form

Careful completion of this form will assist us in providing your child with the best possible care.

Child's Name ______________________ Nickname ______________ Sex: M F D.O.B.____________

Mailing Address Street ______________________________ Home Phone ____________________

City ______________________________ State ____________ Zip ________________

Phone Number to reach Mother/Father during the day ________________________________

Names and Ages of Siblings ________________________________

Who may we thank for referring you? Parent's Name ____________________ Child's Name ____________________

Address ________________________________

City, State, Zip ________________________________

PARENTAL INFORMATION

	FATHER	MOTHER
Name		
Date of Birth		
Home Address: Street		
City, State, Zip		
Telephone Number		
Cell		
Email		
Occupation		
Name of Employer		
Street		
City, State, Zip		
Business Phone		

Social Security Number ________________________________

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

DENTAL INSURANCE

Name of Carrier ________________________________

Policy Number ________________________________ ❑ Father's Plan ❑ Mother's Plan

Carrier Address ________________________________

Carrier Phone Number ________________________________

Name of Carrier ________________________________

Policy Number ________________________________ ❑ Father's Plan ❑ Mother's Plan

Carrier Address ________________________________

Carrier Phone Number ________________________________

I hereby authorize payment directly to Peter B. Geller, D.D.S., David M. Petrarca, D.D.S., P.C. the dental benefits otherwise payable to me.

________________________________ ________________________

SIGNED (Insured Person) DATE

MEDICAL HISTORY

Child's Physician________________________________ Phone #________________

Address ________________________________ City, State, Zip ________________________

Date of Last Physical Examination ________________________________

Is your child being treated by a physician at this time? .... YES NO

If yes, why? ________________________________

Is your child taking any medications at this time? .... YES NO

If yes, what and why? ________________________________

Has your child ever been hospitalized? .... YES NO

If yes, why and when? ________________________________

Has your child ever had any operations? .... YES NO

If yes, why and when? ________________________________

Has your child ever had a blood transfusion? .... YES NO

If yes, why and when? ________________________________

Has your child ever had general anesthesia? .... YES NO

If yes, were there any complications? ________________________________

Is your child allergic to anything? (Medications, Food) .... YES NO

If yes, what?________________________________

Has your child ever been given penicillin? .... YES NO

If yes, were there any complications? ________________________________

Is your child up to date on his/her immunizations? .... YES NO

ORGANS AND SYSTEMS: Has your child ever had any treatment for any of the following? Please check yes or no:

YES	NO		YES	NO	
_____	_____	Blood – Circulatory/ Transfusions	_____	_____	Heart
_____	_____	Bones	_____	_____	Liver
_____	_____	Endocrine Glands	_____	_____	Muscles
_____	_____	Eyes, Ears, Nose, Throat	_____	_____	Nervous System
_____	_____	Gastrointestinal (stomach)	_____	_____	Skin Eczema
_____	_____	Kidney – Bladder	_____	_____	Tonsils/Adenoids
_____	_____	Lungs			

If yes to any of the above, please elaborate: ________________________________

____

ILLNESS: Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

YES	NO		YES	NO	
_____	_____	Anemia	_____	_____	Head Aches
_____	_____	Allergy	_____	_____	Heart Disease
_____	_____	Arthritis	_____	_____	Hemophilia
_____	_____	Asthma/Breathing Problems	_____	_____	Hepatitis – Type __________
_____	_____	Autism	_____	_____	Immune Deficiency/Infections
_____	_____	Birth Defects	_____	_____	Injury/Trauma
_____	_____	Brain Injury	_____	_____	Jaundice
_____	_____	Cancer/Tumors	_____	_____	Learning Disabilities/Developmental Delay
_____	_____	Cerebral Palsy	_____	_____	Leukemia
_____	_____	Chicken Pox or Vaccine	_____	_____	Mental Retardation
_____	_____	Cleft Lip/Palate	_____	_____	Nutritional Deficiency
_____	_____	Convulsions/Seizures	_____	_____	Orthopedic Problems
_____	_____	Diabetes	_____	_____	Rheumatic Fever
_____	_____	Emotional Disturbance/Social Issues	_____	_____	Scoliosis
_____	_____	Epilepsy	_____	_____	Sickle Cell Anemia
_____	_____	Eye Problems	_____	_____	Spina Bifida
_____	_____	Excessive Bleeding Problem	_____	_____	Tetanus
_____	_____	Fainting	_____	_____	Whooping Cough
_____	_____	Hearing Loss	_____	_____	Other

DENTAL HISTORY

Is this your child's first dental visit? .... YES NO

Reason for bringing child for this visit? ____________________

____

Name of child's previous dentist: ____________________ Date of last visit ____________________

Has your child had dental radiographs (x-rays)? .... YES NO

If yes, where were they last taken? ____________________

Has your child ever had local anesthesia (Novocaine)? .... YES NO

If yes, were there any complications? ____________________

Does your child respond well to his/her pediatrician? .... YES NO

Describe your child's temperament ____________________

____

Please indicate if your child has or has had any of the following oral habits:

Breathes through mouth .... YES NO

Sucks thumb or finger .... YES NO If yes, until what age? ____________________

Uses a pacifier .... YES NO If yes, until what age? ____________________

Bites or sucks lips .... YES NO

Tongue habit .... YES NO

Bottle to bed .... YES NO If yes, until what age? ____________________

Other ____________________

Any previous history of traumatic injury to teeth or mouth area? .... YES NO

If yes, please explain ____________________

Do you live in a community with fluoridated water? .... YES NO

Does your child drink tap water? .... YES NO

Does your child use any fluoride supplements (rinses, vitamins)? .... YES NO

If yes, name of product ____________________

How often and when does your child brush his/her teeth? ____________________

Brand of toothpaste? ____________________

Type of toothbrush? Hard ____________________ Soft ____________________

Does your child floss his/her teeth? .... YES NO

When ____________________

Is there parental assistance or supervision when:

Brushing? .... YES NO

Flossing? .... YES NO

Any history of jaw pain (tempromandibular joint pain)? .... YES NO

If yes, please explain ____________________

Additional Remarks: ____________________

____

____

THE SIGNATURE OF A PARENT OR GUARDIAN BELOW AUTHORIZES THE COMPLETION OF ALL AGREED-UPON NECESSARY DENTAL SERVICES.

SIGNATURE ____________________

DATE ____________________

RELATIONSHIP ____________________

PLEASE BRING THIS COMPLETED FORM TO YOUR CHILD'S INITIAL APPOINTMENT.

TO BE COMPLETED BY REVIEWER:

MEDICAL HISTORY SUMMARY:
(Precautions, medical entities, SBE)

____
____
____
____

DENTAL HISTORY SUMMARY:
(Previous experience, OHI, F1 Hx)

____
____
____
____

Reviewer ____ Date ____________________

MEDICAL HISTORY UPDATES (to be completed at subsequent visits by parent or guardian)

DATE ______________________________

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

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Parent's Signature ____ Reviewer ____________________

DATE ______________________________

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

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Parent's Signature ____ Reviewer ____________________

DATE ______________________________

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

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Parent's Signature ____ Reviewer ____________________

DATE ______________________________

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

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Parent's Signature ____ Reviewer ____________________

DATE ______________________________

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

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Parent's Signature ____ Reviewer ____________________