

Pediatric Dentistry  
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Pediatric Dentistry  
Robert A. Frank, D.M.D.  
Orthodontics  
Sven Supplies, D.M.D.  
Moirá K. Casey, D.M.D.

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

## Pediatric Patient Information and Health History Form

REVIEWED BY

Dr./Date

175 Littleton Road  
Westford, MA 01886  
(978) 392-9800 www.childrensdentist.com



80 High Street  
Medford, MA 02155  
(781) 391-8300

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

#### PARENT/GUARDIAN 1

#### PARENT/GUARDIAN 2

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	_____	_____	Intellectual Disability
_____	_____	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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature \_\_\_\_\_ Reviewer \_\_\_\_\_