

# WELCOME TO PEDIATRIC DENTISTRY OF CLIFTON PARK

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 # \_\_\_\_\_

We require positive appointment confirmation. Please provide additional means of contact, and check the preferred method:

- 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. Is your child under the care of a cardiologist? \_\_\_\_\_  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
11. 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 \_\_\_\_\_

**I hereby certify that the information contained in these forms is accurate and complete to the best of my knowledge. I consent to the dental treatment for this patient for whom I am the parent or legally authorized representative. I understand I am responsible for all charges incurred, regardless of the patient's insurance status.**

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