We would like to welcome you to our office. Our goal is to help your child have a pleasant visit while we educate you in the most modern preventive concepts.

Jennifer L. Udis, D.M.D.

Diplomat, American Board of Pediatric Dentistry

Our office practices state of the art infection control as mandated by OSHA, the CDC, and the ADA.

Dentistry for Children

Today's Date _____

ABOUT YOUR FAMILY

Best phone number to confirm appointments: _____ - _____ - _____

Child's Full Name: _____
Nickname: _____
Birthdate: _____ Age _____
Gender: _____ Social Security # ____ - ____ - _____
School Presently Attending: _____
Siblings (Names/Ages): _____
_____
Child's Home Address: _____
_____
Child's Home Phone: _____ - _____ - _____
Physician's Name & Address: _____
_____
Special interests, sports or hobbies: _____
_____
Purpose of appointment: _____
_____
_____
Do you have any special concerns: _____
_____
_____
_____
Referred By: _____

Parent/Guardian #1: _____
Relationship to Child: _____
Occupation: _____
Employer: _____
Work Phone Number: _____
Home Address (if different from Child's): _____
_____
Phone Number (if different from Child's): _____
Email address: _____
Social Security # ____ - ____ - _____

Parent/Guardian #2: _____
Relationship to Child: _____
Occupation: _____
Employer: _____
Work Phone Number: _____
Home Address (if different from Child's): _____
_____
_____
Social Security # ____ - ____ - _____
Phone Number (if different from Child's): _____
Email address: _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS OR CONDITIONS? (Please circle Y/N where appropriate)

Heart murmur	**Y / N**	Any overnight stays in hospital	**Y / N**
Heart problems of any kind	**Y / N**	Any allergies to medications? _____	**Y / N**
Rheumatic fever	**Y / N**	_____	
Hepatitis	**Y / N**	Any allergies to foods? _____	**Y / N**
Convulsions/epilepsy	**Y / N**	_____	
Cancer	**Y / N**	Reaction to local or general anesthetic? If	**Y / N**
Diabetes	**Y / N**	yes, type of reaction: _____	
HIV positive or AIDS	**Y / N**	Is your child taking medications at the present	**Y / N**
Hemophilia	**Y / N**	time? _____	
Bleeding problems of any kind	**Y / N**	_____	
Are inoculations current	**Y / N**	Is your child being treated for a medical	**Y / N**
Hearing impairment	**Y / N**	problem at this time? _____	
Any operations	**Y / N**	_____	
Any diseases with prolonged fevers	**Y / N**	Is your child taking fluoride? If yes, give	**Y / N**
		dose _____	

Are there any other medical conditions:_____

DENTAL HISTORY

(Please circle Y/N where appropriate)

Has your child been to a dentist before? If yes, when: _____ Y / N

Has your child had x-rays taken? Y / N

Have any cavities been noted in the past? Y / N

Have any teeth (baby or permanent) been removed by extraction? Y / N

When does your child brush his/her teeth?_
_____ Morning _____ After snacks
_____ After meals _____ Before bedtime

Have you ever had or heard of nitrous oxide analgesia? Y / N

Does your child receive fluoride? Y / N
_____ Community water
_____ Drops tablets, or vitamin
_____ Toothpaste
_____ Rinse

Has your child ever received a local anesthetic Y / N

Was your child breast fed? If yes, for how long? _____ Y / N

Was your child bottle fed? If yes, for how long? _____ Y / N

Was your child put to bed with a bottle? If yes, for how long? _____ Y / N

Has your child had any bad experiences at another dental office? If yes, please describe: _____
_____
_____ Y / N

Does your child brush daily? Y / N
Do you help? Y / N

Are there any dental problems you are aware of? If yes, please explain: _____
_____
_____ Y / N

Has your child ever had preventive sealants? Y / N

Does your child or did your child suck his/her fingers/thumb or use a pacifier? Y / N

Have there been any injuries to teeth, such as falls, blows, chips, etc.? If yes, please specify: _____
_____ Y / N

Has anyone in the family, including parents, had orthodontics? Y / N

Has your child ever had any problem with dental treatment? If yes, please explain: ____
_____
_____
_____
_____ Y / N

Does your child think there is anything wrong with his/her teeth? If yes, please specify: ____
_____
_____ Y / N

What are your child's favorite snacks? _____
_____

What are your child's favorite drinks? _____
_____

Does your child need to be pre-medicated for any medical reasons before dental treatment? If yes, why? _____
_____
_____ Y / N