Dream Smiles
Pediatric Dentistry of Gaithersburg

New Patient Information

About Your Child

Child's Name: _____

Nickname: _____

Gender: ❑ Male ❑Female Date of Birth:_____

SSN _____

Address: _____

City: _____ State: _____

Zip: _____ Home Phone: _____

Where did you find out about us? _____

School/Daycare does patient attend? _____

Favorite Movie: _____ Book: _____

List any sports or hobbies: _____

Parent's Marital Status:

❑ Married ❑ Divorced ❑ Separated

❑ Widowed ❑ Single

Dental History

❑ Yes ❑ No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child?

_____

_____

❑ Yes ❑ No Do you expect your child to be a cooperative patient? If no, please explain.

_____

❑ Yes ❑ No Does your child take fluoride tablets or vitamins with fluoride?

❑ Yes ❑ No Has your child bumped any teeth? If so, when? _____

❑ Yes ❑ No Has your child had a history of headaches, pain, popping or clicking of the jaws?

❑ Yes ❑ No Does your child have a toothache?

Does your child have any of the following problems or habits?

❑ Thumb Sucking How Long?_____

❑ Finger Habit How Long?_____

❑ Pacifier How Long?

Medical History

Family Physician's Name:_____

Address: _____

Phone Number: _____

• Does your child have to pre-medicate? ❑ Yes ❑ No

• Is your child in good health? If no, explain ❑ Yes ❑ No

_____

• Is your child taking any medications? ❑ Yes ❑ No

If yes, list

_____

• Does your child have any allergies? ❑ Yes ❑ No

_____

• Is your child under the care of a physician for anything other than routine care? If yes, explain ❑ Yes ❑ No

_____

_____

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

❑ Allergy to Penicillin
❑ Latex allergy
❑ Other drug allergy
❑ Intellectual disability
❑ Speech problem
❑ ADD/ADHD
❑ Autism/Asperger's
❑ Bone disorder
❑ Physical handicap
❑ Anemia
❑ Asthma
❑ Liver problems
❑ Hepatitis
❑ Malignancies or leukemia
❑ Bleeding disorder
❑ **If none, please check this box**

❑ Cleft palate
❑ Positive for H.I.V.
❑ Diabetes
❑ Radiation treatment
❑ Endocrine disorder
❑ Rheumatic fever
❑ Epilepsy, seizures
❑ Down Syndrome
❑ Tuberculosis
❑ Heart ailment or murmur.
Type: _____
Is child under the care of a cardiologist or special physician for the problem?
If so, whom
_____

Phone _____

Please comment on any problems that were checked in the above areas

_____

_____

_____

_____

_____

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Dental History

How often does your child brush? _____

Is tooth brushing supervised? ❑ Yes ❑ No

By whom? _____

Is dental floss used? ❑ Yes ❑ No

Emergency Contact

Name: _____

Address: _____

City _____State _____Zip _____

Phone _____ Relationship _____

Responsible Party

Father's Full Name: _____

Phone _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Occupation _____ Employer: _____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

_____

Insurance Company _____

Group or Plan Number _____

Mother's Full Name: _____

Phone _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Occupation _____ Employer: _____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

_____

Insurance Company _____

Group or Plan Number _____

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays, and examinations) before that treatment is performed.

_____

SIGNED (parent or legal guardian) **DATE**