

NEW PATIENT REGISTRATION

PATIENT'S INFORMATION

PATIENT I.D. # _____



Date: _____

Name: _____
FIRST MIDDLE LAST

Date of Birth: ____/____/____ Age (yrs-mos): ____ - ____ Gender: M / F Height: _____ Weight: _____ lbs

Patient Address: _____
STREET CITY STATE ZIP

Home Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____

Legal Guardian for this patient: _____
FIRST MIDDLE LAST

Legal Guardian Address: _____
STREET CITY STATE ZIP

Date of Birth of **Legal Guardian**: ____/____/____ Additional Phone #: (____) _____ - _____

Employer: _____ Work phone #: (____) _____ - _____

Email address: _____

Proof of guardianship is required, as needed (examples: divorce, foster care, adoption)
I have provided proof of guardianship, as needed: YES / NO

Relationship of guardian to patient: _____

Who is the child's Pediatrician? _____ Phone #: (____) _____ - _____

Name of referral source? Pediatrician Referral _____
NAME

or, General Dentist referral _____ or, friend _____
NAME NAME

or, other (e.g., advertisement, Yellow Pages, etc.,) _____

INSURANCES: DENTAL AND MEDICAL

Name of Policy Holder: _____ Social Security # of Insured _____ - _____ - _____
FIRST LAST

Payment Coverage (check all that apply): Medicaid ____ Insurance ____ Self-Pay ____

Dental Insurance Company: _____ Policy Holder Date of Birth: ____/____/____

ID #: _____ Group #: _____

Patient's Relationship to Insured: Self / Son/Daughter / Grandchild / Other _____

Medical Insurance Company: _____

Policy Holder's date of birth (if policy holder is not the patient) ____/____/____

ID #: _____ Group #: _____

Patient's Relationship to Policy Holder: Self / Son/Daughter / Grandchild / Other _____

PLEASE READ BEFORE PROCEEDING

PATIENT NAME _____

Help us better understand the **unique needs of your child and your family**. Most questions are very specific. Please be thorough in your response, so that we may optimize your child's experience, and our dental care.

FAMILY INFORMATION

| Siblings (i.e., brothers, sisters) | Gender | Age | Lives in same home | Patient of Just for Grins ? |
|------------------------------------|--------|-----|--------------------|------------------------------------|
| EXAMPLE: Jonathan | Male | 3 | Yes/No | Yes/No |
| | | | | |
| | | | | |
| | | | | |

Aside from legal guardians and siblings, does anyone else live in the same household as the patient? NO / YES _____
IF YES, WHO

Does child also live in *another* household? (e.g. other parent, grandparent): YES / NO

BIRTH HISTORY

Patient was born at _____ weeks gestation Birth weight: _____ Birth length: _____

Pregnancy abnormalities: _____ Birth abnormalities/congenital defects: _____

Please circle: Vaginal delivery / Planned caesarean section / Unplanned caesarean section

What drugs did mother take during pregnancy? _____

High risk pregnancy? YES / NO Mother received pre-natal care by health professional: YES / NO

Patient was intubated: YES / NO Patient was hospitalized: YES / NO If yes, for how long? _____

DIETARY HISTORY

Breast-fed until age _____ Bottle-fed until age _____ Sippy cup until age _____ Started regular cup age: _____

Slept with milk or juice bottle: YES / NO If yes, until age: _____ Started 2% milk at age: _____ Doesn't drink milk: _____

Started solid foods at age: _____ Child gags easily: YES / NO Caused by: Textures / Certain foods / Quantity of food

Child has difficulty chewing food: YES / NO Child has difficulty swallowing food: YES / NO

History of frequent vomiting: YES / NO Child has: Feeding disorder / Eating disorder / Pica / Obesity / Rumination

Food allergies: none ____ or, please list: _____

Please detail other dietary restrictions: _____

Favorite foods or beverages: _____

Snacking pattern (check all that apply): mid-morning ____ mid-afternoon ____ grazing ____ skips meals ____

Please check all foods that are a typical part of your child's diet.

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Juice (any kind) | <input type="checkbox"/> Animal crackers | <input type="checkbox"/> Gummy snacks | <input type="checkbox"/> Jam / jelly | <input type="checkbox"/> Fruit snacks |
| <input type="checkbox"/> Chocolate milk | <input type="checkbox"/> Lemons | <input type="checkbox"/> Nuts | <input type="checkbox"/> Bananas | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Strawberry milk | <input type="checkbox"/> Granola Bars | <input type="checkbox"/> Chewing gum | <input type="checkbox"/> Sugared cereal | <input type="checkbox"/> Yoghurt |
| <input type="checkbox"/> Kool-Aid | <input type="checkbox"/> Popsicles | <input type="checkbox"/> Hard candy | <input type="checkbox"/> Ice cream | <input type="checkbox"/> Pop Tarts |
| <input type="checkbox"/> Soda Pop | <input type="checkbox"/> Cheetos | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Raisins | <input type="checkbox"/> Graham crackers |
| <input type="checkbox"/> Iced Tea | <input type="checkbox"/> Cheese | <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Dried fruit | <input type="checkbox"/> Potato chips |

DENTAL HEALTH HISTORY

PATIENT NAME _____

Child takes daily fluoride supplements: YES / NO Dosage (mg)?: 0.25 / 0.50 / 1.0

Child's water supply is primarily: town / city of _____ fluoridated? YES / NO well-water? YES / NO

Child drinks only bottled water? YES / NO Family uses tap water for cooking? YES / NO

Child brushes _____ times per _____; flosses _____ times per _____; fluoride toothpaste: YES / NO

Child's oral homecare is: assisted / supervised / unsupervised

Does this child have an immediate dental problem? YES / NO _____
IF YES, PLEASE DESCRIBE

History of toothache? YES / NO _____
IF YES, PLEASE DESCRIBE

History of injury to mouth, teeth, jaws?: YES / NO _____
IF YES, WHEN PLEASE DESCRIBE

Is this your child's first dental visit?: YES / NO _____
IF NO, WHEN

Please check previous dental care: x-rays _____ cleaning _____ fluoride _____ exam _____ filling _____ extraction _____

History of dental treatment under sedation?: YES / NO under general anesthesia?: YES / NO

History of orthodontic care (appliance, braces)?: YES / NO with Dr. _____ when? _____

Has child had any reaction to local anesthesia (i.e. "novocaine" etc.): YES / NO

TMJ (please check all that apply): clicking _____ popping _____ locking _____ tenderness _____ no known problems _____

WHAT IS YOUR CHILD'S ATTITUDE ABOUT "GOING TO THE DENTIST?" *Please check all that apply*

____ undisturbed ____ cool ____ restrained ____ worried ____ panicky
____ calm ____ cheerful ____ tense ____ nervous ____ angry

other: _____

If negative, what do you think motivates this attitude?

Child's attitude at last dental visit (other provider) was: undisturbed _____ nervous _____ anxious _____ panicky _____

At that visit, what was performed? x-rays _____ cleaning _____ fluoride _____ exam _____ filling _____ extraction _____

How do you rate **your own** attitude about dental appointments? undisturbed _____ nervous _____ anxious _____ panicky _____

ORAL HABITS *Please check all that apply (present and past habits):*

____ Thumb sucking ____ Finger nail chewing ____ Cigarette smoking ____ Finger Chewing
____ Finger sucking ____ Mouth breathing ____ Tobacco chewing ____ Tongue thrust
____ Pacifier ____ Gum chewing ____ Lip/cheek chewing ____ Hair chewing
____ Lip / cheek sucking ____ Ice chewing ____ Lip Sucking ____ Pencil/pen chewing
____ Teeth grinding ____ Hard Candy sucking ____ Blanket sucking ____ Snoring
____ Hand chewing ____ Lemon sucking ____ Clothes sucking ____ Lip licking

PATIENT'S INTERESTS AND HOBBIES

PATIENT NAME _____

Interests / Activities / Sports

_____Hobbies / Pets

_____**SOCIAL / SCHOOL / DAYCARE HISTORY**

School / daycare name: _____ Grade: _____ Home schooled: _____

My child: makes friends easily / has difficulty making friends / is shy / is outgoing

Did or does child receive extra help at school?: YES / NO

Did or does child receive physiotherapy?: YES / NO _____
IF SO, HOW OFTENDid or does child receive occupational therapy?: YES / NO _____
IF SO, HOW OFTENDid or does child receive speech therapy?: YES / NO _____
IF SO, HOW OFTENDid or does child receive psychotherapy?: YES / NO _____
IF SO, HOW OFTEN

My child adapts easily to new situations: YES / NO

Please finish sentence: My child adapts better to new situations when / if _____
_____**DEVELOPMENTAL AND BEHAVIORAL HISTORY****C1**

- ___ Mental retardation
- ___ Cerebral palsy
- ___ Epilepsy/Seizures
- ___ Autism
- ___ Mutism
- ___ Muscular dystrophy
- ___ Osteogenesis imperfecta

C2

- ___ Lack of self care
- ___ Lack of receptive language
- ___ Lack of expressive language
- ___ Learning disability
- ___ Lack of mobility
- ___ Lack of self direction
- ___ No capacity for independent living
- ___ Asperger Syndrome

C3

- | | | |
|--------------------------|---|------------------------------|
| ___ Physical/Motor delay | ___ PTSD Post Traumatic Stress Disorder | ___ Learning disorder |
| ___ Sensory disorder | ___ Sleep disorder | ___ Cognitive delay |
| ___ OCD | ___ Anxiety | ___ Socialization difficulty |
| ___ ADHD / ADD | ___ ADHD /ADD w/ meds | ___ Speech / language delay |
| ___ Non-ambulatory | ___ Depression | ___ Communication difficulty |
| ___ Non-verbal | ___ Self-mutilation | ___ Phobia |

___ psychiatric / psychological counseling (please check): ___ history ___ considered in near future

Other: _____

IMMUNIZATION HISTORY

___ all immunizations up-to-date, to my knowledge

___ conscientious objection to immunization ___ tetanus

___ tetanus booster

MEDICAL HEALTH HISTORY

PATIENT NAME _____

Previous hospitalizations: date(s) _____ For (condition or illness): _____

Surgeries: YES / NO _____
IF YES, PLEASE DESCRIBE _____Tonsillectomy: YES / NO _____
WHEN _____Adenoidectomy: YES / NO _____
WHEN _____**Allergy or adverse reaction to:**local anesthesia: YES / NO penicillin: YES / NO cephalosporin: YES / NO sulfa drugs: YES / NO
latex, rubber: YES / NO sedatives: YES / NO insulin: YES / NOOther antibiotic allergies: YES / NO _____
IF YES, PLEASE DESCRIBE _____Other drug allergies: YES / NO _____
IF YES, PLEASE DESCRIBE _____Environmental allergies: YES / NO _____
IF YES, PLEASE DESCRIBE _____Personal or family history of **Malignant Hyperthermia** (allergy to general anesthesia): YES / NO**My child needs antibiotic prophylaxis prior to dental treatment: YES / NO****Current Medications:**____ steroids ____ insulin ____ immunosuppressant drugs ____ psychiatric drug
____ synthroid ____ inhaler (asthma) ____ nebulizer (asthma) ____ oral contraceptives

Other drugs (including over-the-counter, herbals, vitamins, etc.): _____

Child *did* or *does* have the following:

| | | |
|---|-------------------------------------|---------------------------------------|
| ____ heart murmur or mitral valve prolapse | ____ stomach problems | ____ congenital heart disease |
| ____ hypoglycemia | ____ Rheumatic Fever | ____ thyroid condition |
| ____ asthma or respiratory condition | ____ HIV or AIDS | ____ Tuberculosis |
| ____ history of transplant | ____ seizure disorder | ____ anemia |
| ____ bleeding disorder | ____ kidney disorder | ____ liver disorder (e.g., hepatitis) |
| ____ endocrine disorder | ____ diabetes; insulin/diet control | ____ cancer / chemotherapy |
| ____ GERD (gastro esophageal reflux disorder) | ____ radiation therapy | ____ headaches |
| ____ Crohn's Disease | ____ vitamin B12 deficiency | ____ unexplained high fevers |
| ____ MTHFR (Methylenetetrahydrofolate reductase deficiency) | ____ reflux | ____ sleep apnea |

Cleft lip only ____ Cleft palate only ____ Cleft lip and palate ____ Repair / Reconstruction surgery?: YES / NO

Other maxillofacial anomalies _____

other condition(s) _____

Is child exposed to second-hand smoke?: YES / NO

Child has:

____ sour burps ____ abdominal pains ____ indigestion ____ failure to gain weight
____ bad taste after waking ____ difficulty sleeping ____ bad taste after eating

CONSENT

PATIENT NAME _____

Permission for Dental Examination and/or Treatment of a Minor

I am the parent or guardian of the above named patient, who is a minor, and I do hereby authorize and consent to x-rays, photographs, examinations, anesthesia, or dental treatment rendered under the general, direct, or indirect supervision of the attending doctor at **Just for Grins Pediatric Dentistry**.

This authorization will remain in effect until cancelled, by me, **in writing**.

LEGAL GUARDIAN SIGNATURE

PRINT LEGAL GUARDIAN NAME

DATE

WITNESS SIGNATURE

PRINT WITNESS NAME

DATE

The following individual(s) may accompany and/or authorize dental treatment for this minor patient, and act on my behalf (i.e., the legal guardian) as indicated below. Please note that, in order to authorize treatment, the person named must be 18 years or older. **Just for Grins Pediatric Dentistry** reserves the right to postpone delivery of treatment in certain cases when the legal guardian is not present.

| Name | Relation to patient | May accompany | May authorize a change in treatment |
|---------------------|---------------------|---------------|-------------------------------------|
| EXAMPLE: Jane Smith | Grandmother | Yes/No | Yes/No |
| | | | |
| | | | |
| | | | |

LEGAL GUARDIAN SIGNATURE

PRINT LEGAL GUARDIAN NAME

DATE

WITNESS SIGNATURE

PRINT WITNESS NAME

DATE

PLEASE BE WELL ADVISED OF THE FOLLOWING

Only one guardian may accompany patient to examination/treatment room. Guardians may have the option of switching places with the alternate guardian. Other children and guardians are required to remain in the reception area. Liability issues prevail. Just For Grins Pediatric Dentistry cannot be liable for unattended children in the reception area. Thank you for your consideration in this matter.

INITIAL