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.

____ Juice (any kind)
____ Chocolate milk
____ Strawberry milk
____ Kool-Aid
____ Soda Pop
____ Iced Tea

____ Animal crackers
____ Lemons
____ Granola Bars
____ Popsicles
____ Cheetos
____ Cheese

____ Gummy snacks
____ Nuts
____ Chewing gum
____ Hard candy
____ Fried foods
____ Peanut butter

____ Jam / jelly
____ Bananas
____ Sugared cereal
____ Ice cream
____ Raisins
____ Dried fruit

____ Fruit snacks
____ Milk
____ Yoghurt
____ Pop Tarts
____ Graham crackers
____ 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 NAME

PATIENT'S INTERESTS AND HOBBIES

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 OFTEN

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

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

Did 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
____ Cereberal 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
____ Sensory disorder
____ OCD
____ ADHD / ADD
____ Non-ambulatory
____ Non-verbal
____ PTSD Post Traumatic Stress Disorder
____ Sleep disorder
____ Anxiety
____ ADHD /ADD w/ meds
____ Depression
____ Self-mutilation
____ Learning disorder
____ Cognitive delay
____ Socialization difficulty
____ Speech / language delay
____ Communication difficulty
____ 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 / NO

Other 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

PATIENT NAME

CONSENT

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