Candice Sullivan, DDS.

Pediatric Dental Specialist

Dentistry for Toddlers, Adolescents, and the Physically Challenged

Date _____

Tell Us About Your Child

Patient's Full Name _____
Preferred Name _____ ○ male ○ female
Siblings We Treat _____
Patient's Date of Birth ____/____/____ Age _____
School _____ Grade _____
Social Security Number _____
Mailing Address _____
City _____ State _____ Zip _____
Home Phone (____) _____
Email _____

Mother's Information

Name _____
○ Mother ○ Stepmother ○ Guardian
Birth Date _____/_____/_____
Employer _____
Work Number (___) _____ EXT_____
Home Number (___)_____
Cell Number (___) _____
SSN _____ DL#_____
Email _____

Father's Information

Name _____
○ Father ○ Stepfather ○ Guardian
Birth Date _____/_____/_____
Employer _____
Work Number (___) _____ EXT_____
Home Number (___)_____
Cell Number (___) _____
SSN _____ DL#_____
Email _____

Who Is Accompanying the Child Today?

Name _____
Relationship _____
Do you have legal custody of this child? ○ Yes ○ No

Person Responsible for Account

Name _____
Relationship _____
Billing Address _____
City _____ State _____ Zip _____
Home Phone (____) _____
Work (____) _____Ext _____
Email _____

Primary Dental Insurance

Ins. Company Name _____
Ins. Co. Address _____
_____
Ins. Phone (___) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to patient _____

Policy Owner's

Employer _____
DOB _____ SSN _____

Secondary Dental Insurance

Ins. Company Name _____
Ins. Co. Address _____
_____
Ins. Phone (___) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to patient _____

Policy Owner's

Employer _____
DOB _____ SSN _____

Dental History

Is this your child's first visit to a dentist? ……○ **Yes** ○ **No**
If not, how long has it been since the last visit to the dentist? _____
_____
Previous Dentist _____ Were x-rays taken? ……○ **Yes** ○ **No**
Have there been any injuries to the teeth, face, or mouth? ……○ **Yes** ○ **No**
If yes, please explain _____
_____
_____
Why did you bring your child to the dentist today? _____
_____
Does your child have any of the following habits?

- ○ **Y** or **N** Lip Sucking/Biting
- ○ **Y** or **N** Thumb/Finger Sucking
- ○ **Y** or **N** Mouth Breathing
- ○ **Y** or **N** Nursing/Bottle Habits
- ○ **Y** or **N** Trouble Nursing
- ○ **Y** or **N** Nail Biting
- ○ **Y** or **N** Pacifier
- ○ **Y** or **N** Snoring
- ○ **Y** or **N** Teeth Grinding

Has your child ever had a serious or difficult problem associated with previous dental work? ……○ **Yes** ○ **No**
If yes, please explain _____
_____
Is your child's water fluoridated? ……○ **Yes** ○ **No** Is your child taking fluoride supplements? ……○ **Yes** ○ **No**
Does your child brush his/her teeth nightly? ……○ **Yes** ○ **No** Is your child flossing his/her teeth daily? ……○ **Yes** ○ **No**
Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? ……○ **Yes** ○ **No**

Health History

Has your child had any of the following conditions?

- ○ **Y** or **N** ADD/ADHD
- ○ **Y** or **N** Allergies
- ○ **Y** or **N** Autism
- ○ **Y** or **N** Hospital Stays
- ○ **Y** or **N** Cancer
- ○ **Y** or **N** Convulsions/Epilepsy
- ○ **Y** or **N** Tuberculosis
- ○ **Y** or **N** Kidney/Liver Condition
- ○ **Y** or **N** Diabetes
- ○ **Y** or **N** Eating Disorder
- ○ **Y** or **N** Blood Disorder
- ○ **Y** or **N** Hepatitis
- ○ **Y** or **N** Immune Disorder
- ○ **Y** or **N** Depression/Anxiety
- ○ **Y** or **N** Tonsillectomy
- ○ **Y** or **N** Disabilities/Special Needs
- ○ **Y** or **N** Asthma
- ○ **Y** or **N** Hearing/Visual Impairment
- ○ **Y** or **N** Bone/Muscular Disorder
- ○ **Y** or **N** Congenital Birth Defects
- ○ **Y** or **N** Rheumatic/Scarlet Fever
- ○ **Y** or **N** Heart Disease/Murmur

Please discuss any serious medical conditions your child has had _____
_____
Please list all drugs your child is currently taking _____
_____
Is your child currently under the care of a physician? ……○ **Yes** ○ **No**
Physician's Name _____ Phone Number (_____)_____
Please describe your child's current physical health: ○ **Excellent** ○ **Good** ○ **Fair** ○ **Poor**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____
Parent/Guardian Name (Print)

_____ _____
Parent/Guardian Signature Date