Pediatric Dentistry
Laura Sullivan, DMD
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ST JOHNS PEDIATRIC DENTISTRY

Orthodontics
W. Vaughn Holland, DMD MS

Registration & Health History Form

To ensure that your child receives the best care, we ask you to carefully complete this form.
This form is completely confidential, and will be used only for dental and medical reasons.

Tell us about your child

Name: _____ Nickname: _____ ☐ Male ☐ Female Birth date:____/____/____ Age:_____

School: _____ Interests/Hobbies: _____

Home Address: _____ City: _____ State: _____ Zip: _____ Home Phone#: _____

Person Responsible for Account

Mother's Name: _____ Father's Name: _____

Best phone #: (____)_____ ☐H ☐C ☐W Best phone #: (____)_____ ☐H ☐C ☐W

Email: _____ Email:_____

Who can legally consent for your child? ☐Mother ☐Father ☐Other: _____

Whom may we thank for referring you? _____

Dental Insurance

Insurance Company: _____ Insurance Phone #: _____

Address: _____ City: _____ State:_____ Zip: _____

ID or Member #: _____ Group#:_____

Insured Name: _____ Insured SS#: _____ Insured DOB: _____

Relationship to Child: _____

Insurance Authorization: I authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account (such as physicians or dentists involved in my child's care or my insurance company). I authorize my insurance company to pay directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. **I understand that I will be responsible for all co-payments, deductibles, and any services not paid in full or in part by my insurance company.**

Signature _____ Date: _____ Relationship to patient: _____

Dental History

Previous Dental Care

Is this your child's first visit to the dentist? ☐Y ☐N

Previous dentist (if applicable):_____

If your child has been to the dentist previously were there any problems? Y N

If yes, please explain: _____

Reason for today's visit?_____

_____

Any injuries to the teeth, face, or mouth? Y N

If yes, please explain: _____

Family history of dental problems? Y N

If yes, please explain: _____

Dental care at home

When does your child brush? AM PM After meals

Do you help in brushing your child's teeth? Y N

Does your child use dental floss in cleaning their teeth? Y N

How often?_____

Primary source of drinking water:

☑City ☐Well ☐Bottled ☐Filtered/reverse osmosis

Has your child had any of the following forms of fluoride?

☐Fluoride toothpaste
☐Fluoride rinse
☐Professional topical application
☐Fluoride supplement

Do any of the following apply to your child?

Frequent snacking Y☐ N☐ Thumb/finger sucking Y☐ N☐
Sleeps with bottle Y☐ N☐ Pacifier use Y☐ N☐
Sippy cup use Y☐ N☐ Mouth breathing Y☐ N☐
Breast feeding Y☐ N☐ Tooth grinding Y☐ N☐
Cups per day of: Juice_____ Soda_____ Sports drinks_____
Cups per night of: Juice_____ Soda_____ Sports drinks_____

Is there anything else you would like to tell us regarding your child's dental health? _____

_____

Medical History

Does your child have or has your child had any of the following?
(Please circle)

- ☐Y ☐N Health conditions requiring antibiotics or other medications prior to dental treatment
- ☐Y ☐N Previous hospitalization, surgery, or injury
- ☐Y ☐N Congenital anomalies/ Cleft Lip/Palate
- ☐Y ☐N Adenoid, Tonsil, or Ear Infections
- ☐Y ☐N Hearing, Visual, or Speech Impairments
- ☐Y ☐N Apnea or Snoring
- ☐Y ☐N Congenital Heart Defect/disease or Heart Murmur
- ☐Y ☐N High or Low Blood Pressure
- ☐Y ☐N Asthma or Reactive airway disease
  - Triggers: _____
  - Last attack: _____
  - Hospitalizations: _____
- ☐Y ☐N Cystic fibrosis, Tuberculosis, or Lung problems
- ☐Y ☐N Dietary restrictions or Eating disorder
- ☐Y ☐N Gastroesophageal Acid Reflux disease
- ☐Y ☐N Liver disease or Hepatitis
- ☐Y ☐N Kidney problems or infections
- ☐Y ☐N Bone or Joint problems
- ☐Y ☐N Dermatologic conditions
- ☐Y ☐N Autism
- ☐Y ☐N Developmental disorders
- ☐Y ☐N Cerebral palsy
- ☐Y ☐N Seizures/Epilepsy or Fainting
- ☐Y ☐N Hydrocephaly
- ☐Y ☐N Emotional or Psychological problems
- ☐Y ☐N ADD/ADHD
- ☐Y ☐N Diabetes
- ☐Y ☐N Thryroid or Hormonal problems
- ☐Y ☐N Anemia or Sickle Cell disease/Trait
- ☐Y ☐N Bleeding problems or disorder
- ☐Y ☐N Cancer, Tumor, or Leukemia
- ☐Y ☐N HIV/AIDS
- ☐Y ☐N Immune disorder
- ☐Y ☐N Pregnancy

If "YES", please explain: _____

_____

_____

Please list all medications (including over-the-counter medications, vitamins, and herbal supplements): _____

_____

_____

_____

_____

Allergies/sensitivities/reactions

- ☐ Drugs or medications:_____
- ☐ Environmental (Latex, Food, Dyes, Metal, Acrylic):_____
- ☐ Anesthetics, local and general:_____
- ☐ Sedative agents:_____
- ☐ Other: _____

Other Concerns

_____

_____

_____

_____

_____

Medical Provider

Physician name: _____

Phone: _____

Address: _____

City: _____ State:_____ Zip: _____

For Office Use

General Treatment Consent: I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services are rendered. I give my consent to the doctors and their staff to perform a dental exam, cleaning, and radiographs if needed for proper diagnosis. If required, I also consent to any treatment, services, medication, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Signature: _____ Relationship to child: _____ Date:_____