Has your child ever been hospitalized? if so ..... Yes No

When?_____

For what reason?_____

Has your child had any operations? if so ..... Yes No

When?_____

For what reason?_____

Was general anesthesia used? ..... Yes No

Any complications?_____

Does your child bruise easily?..... Yes No

Has there ever been any history of spontaneous bleeding (e.g. Nose bleeds) or prolonged bleeding following tooth removal surgery, cuts etc.?..... Yes No

3. Growth and Development

Age child's first tooth noticed _____

Age child lost first tooth _____

Age first spoke a word _____

Age first started to walk _____

General Development would be ☐ Early ☐ Average ☐ Late

4. Family History (with whom child resides)

Is mother living?..... Yes No

Is father living?..... Yes No

Are parents living together?..... Yes No

Are mother's teeth and gums in good health?..... Yes No

Are father's teeth and gums in good health?..... Yes No

Has either parent had a past history of hepatitis?..... Yes No

5. Remarks _____

The signature of a parent or guardian affixed below authorizes the completion of all mutually agreed upon necessary dental services

Signature _____ Relationship _____ Date _____

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE (√)	CHANGES	Parent Initial

DATE OF RECORD_____

PERSONAL QUESTIONNAIRE FOR NEW PATIENTS

Please complete and return this form on the first visit. If space is inadequate use remark section. Thank you for your cooperation
(Questions are BOTH SIDES of each page)

PERSONAL

Child's Name_____ Date of Birth_____

Nickname_____ Place of Birth_____

Mother's Name_____ Social Security #_____ Birthdate_____ Occupation_____

Father's Name_____ Social Security #_____ Birthdate_____ Occupation_____

Home Address Street _____

City _____ State _____ Zip _____ Phone # _____

Mother's Business Address Street _____

City _____ State _____ Zip _____ Phone # _____

Father's Business Address Street _____

City _____ State _____ Zip _____ Phone # _____

Child's Physician Address _____

Street _____

City _____ State _____ Zip _____ Phone # _____

Child's Previous Dentist (if applicable) _____

Address Street _____

City _____ State _____ Zip _____ Phone # _____

Age and Name of Siblings _____

Who Can We Thank for Referring You?_____

Contact e-mail_____

HEALTH INSURANCE INFORMATION

Dental Coverage ☐

Company _____

Policy # _____

Name of Policy Holder _____

Child's Social Security # _____

Medical Coverage ☐

Company _____

Policy # _____

Name of Policy Holder _____

DENTAL HEALTH HISTORY

X the main reason for the first visit. Also place **√** next to the problems about which you are concerned

☐ First Examination ☐ Crowding of Teeth ☐ Thumb Habit ☐ Staining or Discoloration ☐ Routine Check-up

☐ Accident ☐ Other Habits ☐ Broken Tooth ☐ Toothache or swelling ☐ Cavities

☐ Bleeding Gums ☐ Snoring ☐ Other Problems

1985 East Main Road ● P.O. Box 382 ● Portsmouth, RI 02871
Telephone: (401) 683-0112 ● Fax (401) 683-2171

Please circle either YES or NO. Please complete all questions

Past dental history of your child:

1. Is this the first visit to a dentist? ..... Yes No
2. If your child has been to a dentist previously
   a. When was the last visit?_____
   b. Have X-rays been taken and when? Date_____
   c. How did your child react and describe his/her temperament?_____
   _____
3. How do you think your child will react to dental treatment?
   _____
4. Has you child had fluoride in any of the following forms?
   Fluoride tablets or in multiple vitamins..... Don't know Yes No
   Drinking water (community fluoridation)..... Don't know Yes No
   Topical Application on teeth, last _____..... Don't know Yes No
   Toothpaste brand _____
5. Does your child brush his/her own teeth? ..... Yes No
   How frequently and when? ☐ A.M. ☐ P.M. ☐ After Snacks ☐ Before Bed ☐ After Breakfast
6. Do you brush your child's teeth? ..... Yes No
   How frequently and when? ☐ A.M. ☐ P.M. ☐ After Snacks ☐ Before Bed ☐ After Breakfast
7. Do you or your child use dental floss in cleaning your child's teeth? ..... Yes No
   How frequently and when? ☐ A.M. ☐ P.M. ☐ After Snacks ☐ Before Bed ☐ After Breakfast
8. Does your child have between meal snacks? ..... Yes No
9. Have your child's teeth ever been injured? ..... Yes No
   When? _____
   Which Teeth? _____
   Cause? _____
   Were the teeth treated? ..... Yes No
   If so describe treatment _____
10. Has your child received any unusual dental or surgical treatment to the mouth? ..... Yes No
    If so, what _____
    _____
11. Does your child have any of the following habits ? (indicate ages when occurred)
    Bottle to bed at night or nap? _____
    What was in the bottle? _____
    Use a pacifier? _____
    Thumb or finger sucking? _____
    Tongue thrusting? _____
    Lip sucking or biting _____
    Mouth breathing? _____
    Grinds Teeth? _____
    Sippy Cup? _____
12. Does your child tend to get frequent headaches?..... Yes No
    How Often? _____ Duration? _____
. Does your child tend to get frequent earaches?..... Yes No
    How Often? _____

Does your child' tend to complain of clicking, popping or crunching noises in his/her ears while chewing? ..... Yes No

MEDICAL HISTORY

(Questions asked so hereditary factor may be evaluated)

1. Birth History
   Was child born premature? ..... Yes No
   Where there any problems during pregnancy? ..... Yes No
   Did you take any medicine during pregnancy? ..... Yes No
   Where there any problems with the delivery? ..... Yes No
   Did child go home with mother? ..... Yes No
   Did your child have pneumonia or staph infection during the first year? ..... Yes No
   Is this child adopted? ..... Yes No
   Any other information that might be pertinent?_____
   _____
2. General Health
   Is a physician treating your child now for a specific illness? ..... Yes No
   If so, for what reason?_____
   Is your child taking any medications at this time? ..... Yes No

Drug	Dose	Frequency	Reason

Has your child taken any unusual medications in the past? ..... Yes No
If so, what?_____

Has your child shown any allergies or unusual reactions?..... Yes No
Medications or drugs?_____
Foods (i.e. Bananas, avocado, kiwi, fruit)?_____
Latex (i.e. Rubber gloves, balloons, etc,)?_____
Metals (i.e. Jewelry)?_____
Other_____

Has your child had immunizations? ..... Yes No
☐ Up to date ☐ Not up to date
Explain:_____

Does your child have any history of the following diseases or conditions?

☐ Rheumatic Fever ☐ Hepatitis ☐ Aids / Related Disorders ☐ 5ths Disease
☐ Heart Murmur, Type?_____
☐ Bleeding Problems ☐ Diabetes ☐ Kidney Disease ☐ Chicken Pox
☐ Seizures ☐ Anemia ☐ Ear Infections ☐ Asthma
☐ Cerebral Palsy ☐ Pneumonia ☐ Liver Disease ☐ Digestive Disorders
☐ Learning Disabilities, Type?_____
☐ Hearing Difficulty, Type?_____
☐ Emotional Disabilities, Type?_____
☐ Speech difficulty, Type?_____