St. Paul Pediatric DENTISTRY

New Patient Social History

Welcome to our office!

Today's Date _____

Childs's Name:_____ MI: _____ Preferred Name:_____

Birthdate:_____ Age:_____ Gender: ☐ MALE ☐ FEMALE

Names and Ages of Siblings: _____

List children who are current patients with us: _____

Parent Name:_____ Birthdate:_____

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

Employer:_____ Business Phone:_____

Cell Phone: _____ Home Phone: _____

E-mail address: _____

Parent Name:_____ Birthdate:_____

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

Employer:_____ Business Phone:_____

Cell Phone: _____ Home Phone: _____

E-mail address: _____

PARENTS: ☐ Married ☐ Single ☐ Divorced || CHILD LIVES WITH: ☐ Mom ☐ Dad ☐ Other: _____

Please provide a relative we may contact in case of an emergency.

Name: _____ Phone Number: _____

Relationship to child:_____

How did you hear about our office?

_____

What is the primary language spoken at home?_____

If English is a second language in the home of the child, we request that you bring a translator to each visit. Please provide us with a name of a friend or relative who speaks English that we may contact if necessary.

Name: _____ Phone Number: _____

St. Paul Pediatric DENTISTRY

Childs Name: _____ DOB: _____

Medical History

Today's date: _____

Child's Physician: _____ Phone #:_____

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

Has your child had a physical exam in the last year? Y / N Is your child up to date on current immunizations? Y/N

Is your child currently receiving medical treatment or seeing a specialist for an illness or condition?	NO YES Please explain: _____
Has your child received emergency medical treatment in the past year?	NO YES Please explain: _____
Has your child ever been hospitalized, had any surgeries, or any major illnesses?	NO YES Please explain: _____
Has your child ever required an antibiotic prior to having any dental treatment completed?	NO YES Please explain: _____
Has your child taken any medications or herbal remedies in the past 6 months?	NO YES Please list: _____
Does your child have any allergies we should be aware of such as latex, medications, foods, or environmental?	NO YES Please list: _____
Is your child currently receiving speech, occupational, or physical therapy?	NO YES Please explain: _____

HAS YOUR CHILD EVER BEEN AFFECTED BY ANY OF THESE CONDITIONS?

Loss of Consciousness	NO	YES	Liver Disease	NO	YES	Hearing Impairment	NO	YES
Recurrent Headaches	NO	YES	Eczema/Skin Disease	NO	YES	Cleft Lip/Palate	NO	YES
Seizures/Epilepsy	NO	YES	Hepatitis	NO	YES	Bone Disorders	NO	YES
Down Syndrome	NO	YES	AIDS/HIV	NO	YES	Endocrine Disorders	NO	YES
Mental Delay	NO	YES	Sickle Cell Anemia	NO	YES	Thyroid Disorders	NO	YES
Developmental Delay	NO	YES	Tuberculosis	NO	YES	Diabetes	NO	YES
Autism Spectrum Disorder	NO	YES	Lung Disease	NO	YES	Blood Disorder	NO	YES
Hyperactivity/ADHD	NO	YES	Asthma	NO	YES	Abnormal Bleeding	NO	YES
Emotional Disorders	NO	YES	Pneumonia	NO	YES	Anemia	NO	YES
Eating Disorders	NO	YES	Breathing Difficulties	NO	YES	Hemophilia	NO	YES
Stomach Problems	NO	YES	Nose/Throat Disorders	NO	YES	Heart Murmur	NO	YES
Kidney Disease	NO	YES	Eye Disorders	NO	YES	Heart Disease/Defect	NO	YES

Please explain conditions above that your child has or has had:_____

I acknowledge that the information above is correct and grant SPPD permission to provide my child's dental treatment as deemed necessary. If my child ever has a change in his/her health or medication, I will inform the Doctor at the next appointment without fail.

SIGNATURE: _____ DATE: _____

St. Paul Pediatric DENTISTRY

Childs Name: _____ DOB: _____

Dental History

Today's date: _____

Previous Dentist Name: _____

Reason no longer being treated with this dentist: _____

What is your greatest concern regarding your child's teeth? _____

Has your child ever had a negative dental experience? NO YES:_____

Are you, or is your child anxious about dental care? NO YES:_____

At what age did your child's first baby tooth come in? _____

Has either parent had a significant amount of dental cavities? NO YES:_____

Has your child had a significant amount of dental cavities or NO YES:_____

treatment now, or in the past? _____

Has your child had a recent toothache? NO YES:_____

Has your child had any traumatic injuries to the teeth or mouth? NO YES:_____

Does your child snore or grind their teeth? NO YES:_____

Was or is your child a pacifier user or thumb sucker? NO YES: If yes, how long? _____

Was or is your child breastfed? NO YES: If yes, how long? _____

Was or is your child bottle fed? NO YES: If yes, how long? _____

Does your child use a sippy cup? NO YES: Throughout the day or with meals? (Circle)

Does your child drink juice or pop on a daily basis? NO YES:_____

Does your child drink fluoridated tap/bottled water? NO YES:_____

Does your child take a fluoride supplement? NO YES:_____

How often are the child's teeth bushed and who brushes? _____

Does your child use a fluoridated toothpaste? NO YES:_____

Do you have any strong feelings about medicine or dentistry _____

that we should be aware of? _____

As a minor child, it is necessary that permission be obtained from a parent or guardian before any dental care can begin. I grant SPPD permission to provide my child's dental treatment as deemed necessary and I will be responsible for the cost of this dental care. For specific procedures, further information will be provided.

SIGNATURE:_____ DATE:_____