St. Paul Pediatric DENTISTRY

New Patient Social History

Today's Date _____

CHILD'S Name _____ Preferred Name _____

Birthdate _____ Age _____ Gender: Male ☐ Female ☐

Names & Ages of Siblings _____

Please list children who are current patients with us

_____

FATHER'S Name _____ Birthdate _____

Home Address _____ City _____ State _____ Zip _____

Employed By _____ Business Phone _____

Cell Phone _____ Home Phone _____

E-mail _____

MOTHER'S Name _____ Birthdate _____

Home Address _____ City _____ State _____ Zip _____

Employed By _____ Business Phone _____

Cell Phone _____ Home Phone _____

E-mail _____

Parents: Married ☐ Single ☐ Divorced ☐

Please provide a person we may contact in case of an emergency:

Name _____ Home Phone _____

How did you hear about our office?

_____

What is the primary language spoken in the child's home? _____

If English is the 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 _____ Home Phone _____

St. Paul Pediatric DENTISTRY

New Patient Medical History

Child's Name _____ Birthdate _____

Today's Date _____

Child's Physician _____ Phone # _____

Physician's Address _____ City _____ State _____ Zip _____

Has your child had a physical exam in the last year?

Is your child currently receiving medical treatment for an illness or condition? Please explain

_____

Is your child up to date on the current immunization recommendations?

Has your child received emergency medical treatment in the past year? Please explain

_____

Has your child ever been hospitalized, had a serious illness, or operation? Please explain

_____

Has your child ever required an antibiotic prior to dental treatment?

Please list any medications or herbal remedies your child has taken in the past 6 months:

_____

Please list any foods or medications your child is allergic to:

_____

Has your child been affected by any of the following conditions:

- ☐ Loss of Consciousness
- ☐ Recurrent Headaches
- ☐ Seizures/Epilepsy
- ☐ Mental Retardation
- ☐ Emotional Problems
- ☐ Hyperactivity/ADHD
- ☐ Eating Disorders
- ☐ Stomach problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Skin Disease
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ Sickle-Cell Anemia
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Asthma
- ☐ Pneumonia
- ☐ Breathing Difficulties
- ☐ Nose/Throat Disorders
- ☐ Eye Disorders
- ☐ Hearing Impairment
- ☐ Cleft Lip/Palate
- ☐ Bone Disorders
- ☐ Endocrine Disorders
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Blood Disorder
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Hemophilia
- ☐ Heart Murmur
- ☐ Heart Disease/Defect

Please explain any above conditions that your child has or has had

_____

Is your child currently receiving speech therapy? If yes, from whom? _____

St. Paul Pediatric DENTISTRY

New Patient Dental History

Child's Name _____ Birthdate _____

Today's Date _____

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

Are you, or is your child, anxious about dental care? ☐

Has your child had a recent toothache? ☐

Who was your child's previous dentist? _____

Reason your child is no longer being treated with this dentist? _____

Has your child ever had a negative dental experience? _____

Has either parent had a significant amount of dental decay or treatment in the past? ☐

Has your child had a significant amount of dental decay or treatment now or the past? ☐

Has your child had any traumatic injuries to the teeth or mouth? ☐

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

Was or is your child a pacifier user or thumb sucker? ☐

Does your child snore or grind teeth? _____

Was your child breastfed? If yes, for how long? _____

Was your child bottle fed? If yes, for how long? _____

Does your child use a sippy cup? Throughout the day or with meals? _____

Does your child drink juice or pop on a daily basis? ☐

Does your child drink fluoridated tap water? ☐

Does your child currently take a fluoride supplement? ☐

How often are the child's teeth brushed? _____ Who brushes the child's teeth? _____

Does your child use a fluoridated toothpaste? ☐

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 acknowledge that the above information 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 his/her medications change, I will inform Dr. Haman at the next appointment without fail. I will be responsible for the cost of this dental care. For specific procedures, further information will be provided.

Signature Date

_____