STONE RIDGE
PEDIATRIC DENTISTRY

YOUR CHILD'S SMILE, OUR PASSION

New Patient Paperwork

About Your Child

Child's Name: _____

Nickname: _____

Gender: Male Female Date of Birth: _____

SSN _____

Address:_____

City: _____State: _____

Zip: _____ Home Phone: _____

How did you find out about us? _____

School / Daycare does patient attend? _____

Favorite Movie: _____

Favorite Book: _____

List any sports or hobbies: _____

Emergency Contact

Name: _____

Address: _____

City _____State _____Zip _____

Phone _____

Relationship _____

Responsible Party

Responsible Party's Full Name: _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

_____

Insurance Company _____

Group or Plan Number_____

Insurance Company Phone _____

Parent's Marital Status:
❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single

Secondary Party: _____

Address: _____

City _____State _____ Zip _____

SS# _____ Birthdate _____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

_____

Insurance Company _____

Group or Plan Number_____

Insurance Company Phone _____

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays, and examinations) before that treatment is performed.

_____

SIGNED (parent or legal guardian) **DATE**

Dental History

❑ Yes ❑ No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child?

_____

_____

❑ Yes ❑ No Do you expect your child to cooperate? If no, please explain.

_____

❑ Yes ❑ No Does your child take fluoride tablets or vitamins with fluoride?

❑ Yes ❑ No Has your child bumped any teeth? If so, when?

❑ Yes ❑ No Has your child had a history of headaches, pain, popping or clicking of the jaws?

❑ Yes ❑ No Does your child have a toothache?

Does your child have any of the following habits?

❑ Thumb Sucking How Long?_____

❑ Finger Habit How Long?_____

❑ Pacifier How Long?_____

How often does your child brush? _____

Is tooth brushing supervised? ❑ Yes ❑ No

By whom?_____

Is dental floss used? ❑ Yes ❑ No

What is your primary concern about your child's oral health?

_____

Family history of cavities?❑ Yes ❑ No

Is your child a 'picky eater'? ❑ Yes ❑ No

Anything else you want us to know? ❑ Yes ❑ No

_____

Please indicate if your child has had any of the following:

❑ Yes ❑ No Inherited dental characteristics

❑ Yes ❑ No Mouth sores or fever blisters

❑ Yes ❑ No Bad breath

❑ Yes ❑ No Bleeding gums

❑ Yes ❑ No Cavities/decayed teeth

❑ Yes ❑ No Toothache

❑ Yes ❑ No Injury to teeth, mouth or jaws

❑ Yes ❑ No Clinching/grinding his/her teeth

❑ Yes ❑ No Jaw joint problems (popping, etc.)

Medical Information

Family Physician's Name:_____

Address: _____

Phone Number: _____

Does your child require antibiotics before dental procedures?

❑Yes ❑ No

Is your child in good health? If no, explain ❑Yes ❑No

_____

Is your child under the care of a physician for anything other than routine care? If yes, explain ❑Yes ❑ No

_____

Does your child have any food/drug allergies? ❑Yes ❑ No

_____

Is your child taking any medications? ❑ Yes ❑ No

If yes, list._____

Is child under the care of a cardiologist or special physician for the problem?

If so, whom: _____

Has your child been hospitalized recently? ❑ Yes ❑No

If so, when: _____

Medical History

Please indicate if your child has had any of the following:

❑ Yes ❑ No Abnormal Bleeding Problems
❑ Yes ❑ No AIDS or HIV
❑ Yes ❑ No Allergies (hayfever, pollen)
❑ Yes ❑ No Latex allergy
❑ Yes ❑ No Anemia
❑ Yes ❑ No Asthma
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Autism
❑ Yes ❑ No Bladder Disorder
❑ Yes ❑ No Blood Disorder
❑ Yes ❑ No Cancer
❑ Yes ❑ No Cerebral Palsy
❑ Yes ❑ No Premature Delivery
❑ Yes ❑ No Radiation Therapy
❑ Yes ❑ No Emotional Problems
❑ Yes ❑ No Thyroid (high or low)
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Epilepsy or Seizures
❑ Yes ❑ No Fainting/Dizziness
❑ Yes ❑ No Hearing Problems
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Heart Problems
❑ Yes ❑ No Hepatitis
❑ Yes ❑ No ADD/ADHD
❑ Yes ❑ No Kidney Disorders
❑ Yes ❑ No Learning Disabilities
❑ Yes ❑ No Liver Disorders
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Ear, Nose, or Throat Problems
❑ Yes ❑ No Sleep Apnea
❑ Yes ❑ No Frequent Headaches
❑ Yes ❑ No Tonsils Removed
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Birth defects or growth issues
❑ Yes ❑ No GERD, stomach ulcer, or intestinal issues

Infant/Toddler History

Please complete the following supplemental history for your infant/toddler.

Please indicate if your child has had any of the following:

Was your child born prematurely? ❑ Yes ❑ No

If yes, what week?_____

What was your child's birth weight? _____

How long was your child breast-fed? _____

How long was your child bottle-fed? _____

Do/did you feed your child infant formula? ❑ Yes ❑ No

If yes, what type?

❑ Ready to use❑ Powder ❑ Liquid Concentrate

Does/did your child sleep with a bottle? ❑ Yes ❑ No

If yes, content of bottle? _____

Does/did your child use a no-spill sippy cup? ❑ Yes ❑ No

Child's age (in mos) when first tooth appeared: _____

Has your child experienced teething issues? ❑ Yes ❑ No

When did you begin brushing their teeth? _____

When did you begin using toothpaste? _____

Who is your child's primary care taker during the day?

_____ Evening? _____

Name/age of siblings at home: _____

_____

_____

_____

_____