# Poiset and Associates

## Pediatric Dentistry and Orthodontics

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## Please Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nick Name:_____ ☐ Male ☐ Female

Child's Date of Birth:_____/_____/_____ Child's Age:_____

Attends What School:_____

Is your child adopted? ☐ Yes ☐ No Does the child know? ☐ Yes ☐ No

Brother's names & ages:_____

Sister's names & ages:_____

## Dental History

| | Yes | No |
|---|---|---|
| Is this the child's first visit to the dentist? _____ | ☐ | ☐ |
| Any unfavorable experiences in another dental office?_____ | ☐ | ☐ |
| Are there any specific concerns about the child's mouth or teeth?__ | ☐ | ☐ |

Please describe further, if necessary:_____

_____

_____

How many times per day are the child's teeth brushed?

☐ 0 ☐ 1 ☐ 2 ☐ 3

| | | |
|---|---|---|
| Are the child's teeth flossed daily?_____ | ☐ | ☐ |
| Does an adult assist with brushing and flossing the child's teeth?__ | ☐ | ☐ |
| Is fluoride toothpaste used?_____ | ☐ | ☐ |

Does the child use any additional fluoride products?

☐ Rinse ☐ Gel ☐ Water ☐ Tablets or Drops

| | | |
|---|---|---|
| Has the child had or does the child need orthodontic treatment?___ | ☐ | ☐ |
| Does the child currently nurse?_____ | ☐ | ☐ |
| Does the child currently use a bottle or sippy cup?_____ | ☐ | ☐ |
| If yes, does the child have the bottle or sippy cup in bed?_____ | ☐ | ☐ |
| Any TMJ pain or symptoms(clicking, popping, limited opening)?___ | ☐ | ☐ |
| Has the child had any injuries to the mouth or face?_____ | ☐ | ☐ |

If yes, please describe:_____

_____

Does the child have any of the following habits?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Pacifier Use | ☐ | ☐ | Grinds Teeth |
| ☐ | ☐ | Thumb or Finger Sucking | ☐ | ☐ | Bites Nails |
| ☐ | ☐ | Lip Sucking or Licking | ☐ | ☐ | Tongue Thrust |

## Health History

| | Yes | No |
|---|---|---|
| Has the child ever had a serious illness?_____ | ☐ | ☐ |

If yes, please explain_____

_____

| | | |
|---|---|---|
| Has the child ever been hospitalized?_____ | ☐ | ☐ |
| Has the child ever had surgery?_____ | ☐ | ☐ |
| Does the child have a syndrome or genetic disorder?_____ | ☐ | ☐ |
| Any congenital birth defects or craniofacial defects?_____ | ☐ | ☐ |
| Any physical or mental disabilities?_____ | ☐ | ☐ |
| Is the child on the autistic spectrum?_____ | ☐ | ☐ |

**Has the child had a history of, or condition related to the following?**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Leukemia |
| ☐ | ☐ | Lung Disease | ☐ | ☐ | Developmental Delay |
| ☐ | ☐ | Kidney Disease | ☐ | ☐ | Speech Delay |
| ☐ | ☐ | Liver Disease/Hepatitis | ☐ | ☐ | Hyperactive / ADD |
| ☐ | ☐ | Endocrine System | ☐ | ☐ | Sensory Integration |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Vision Impairment |
| ☐ | ☐ | GI Disease | ☐ | ☐ | Hearing Impairment |
| ☐ | ☐ | Acid Reflux / GERD | ☐ | ☐ | Seizures or Epilepsy |
| ☐ | ☐ | Celiac or Irritable Bowel | ☐ | ☐ | Premature Birth |
| ☐ | ☐ | Hemophilia/Bleeding Disorder | ☐ | ☐ | Cerebral Palsy |
| ☐ | ☐ | Blood Disorder | ☐ | ☐ | Skin Disorder |
| ☐ | ☐ | Cancer or Tumors | | | |

Please discuss medical conditions further, if necessary:_____

_____

_____

Please list Allergies (medication, foods, latex): _____

_____

Please list any medications the child is taking:_____

_____

_____

Does the child have any of the following breathing issues?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Asthma | ☐ | ☐ | Enlarged Tonsils/Adenoids |
| ☐ | ☐ | Environmental Allergies | ☐ | ☐ | Sleep Apnea |
| ☐ | ☐ | Snoring | ☐ | ☐ | Trouble Breathing Through |

Child's Physician:_____

Phone Number: (_____)_____

**I understand that, the information I have given on this form is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may require.**

_____ _____ _____

**Parent/Guardian Signature** **Parent/Guardian Printed Name** **Date**

| Dentist's Review | Update | Update | Update | Update | Update |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| Signature Date | Signature Date | Signature Date | Signature Date | Signature Date | Signature Date |