PetitSmiles
PEDIATRIC DENTISTRY

Patient Registration: Biographical Information

Today's Date: .....
month/day/year

Patient's Name: ..... Date of Birth: .....
First Last month/day/year

Preferred Name: ..... Sex: male female

SSN: .....-.....-.....

School: ..... Grade: ..... City: .....

# of brothers? ..... # of sisters? .....

Siblings:

brother sister name ..... age .....

brother sister name ..... age .....

brother sister name ..... age .....

Has your child had any bad dental or medical experiences in the past? N Y

If yes, please explain.....

Please check any of the following that may describe your child:

outgoing	anxious	hyper	defiant	trusting	suspicious	shy
mellow	curious	stubborn	friendly	moody	cooperative	

Child's Interests: .....

Favorite Sport: .....

Favorite Movie: .....

How do you expect your child to react to his/ her visit today?

excellent good fair poor don't know

Whom may we thank for referring you to our office ? .....

Who is this? dentist physician teacher relative friend other

1535 Sunset Drive, Coral Gables, Fl . 33143
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Parent Information

Mother's name: ..... Father's name: .....

Address: ..... Address: .....

City:..... State: ..... Zip: ..... City:..... State: ..... Zip: .....

Home phone: ( ) ..... Home phone: ( ) .....

Cell phone: ( ) ..... Cell phone: ( ) .....

e-mail:..... e-mail:.....

Date of birth: ...../...../..... Date of birth: ...../...../.....

SSN: .....-.....-..... SSN: .....-.....-.....

Drivers license #..... State: ..... Drivers license #..... State: .....

Occupation: ..... Occupation: .....

Employer name: ..... Employer name: .....

Employer address: ..... Employer address: .....

....

City: ..... State: ..... Zip: ..... City: ..... State: ..... Zip: .....

Work phone: ( ) ..... Work phone: ( ) .....

Who does the child live with? both parents mother father other .....

Name of person responsible for this account: ..... Relationship: .....

IN CASE OF EMERGENCY, who should we contact? (Please specify if it is someone who does not live in your household)

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Name: ..... Home phone: ( ) .....

Relationship: ..... Work phone: ( ) .....

Patient Registration Dental and Medical Health History

Dental History

1. Is this your child's first dental visit? Yes No

Previous dentist's name: ..... Date of last visit: .....

2. Has your child ever had problems receiving dental care? Yes No

Please explain.....

3. Is there a particular problem with your child's teeth that prompted you to visit our office? Yes No

Please explain.....

4.

Does your child brush daily? Yes No

Does an adult assist with brushing? Yes No

Does your child floss? Yes No

How often? .....

Does an adult assist with flossing? Yes No

5. Is the patient receiving fluoride in any form? Yes No

If yes, please circle:
Vitamins Water Supply Toothpaste Tablets or Drops Rinse or Gel

6. Does your child have any of the following habits?

Thumb / Finger Sucking Lip Sucking Tongue thrust Pacifier

Mouth Breathing Teeth Grinding Nail Biting

7. Has your child ever had any injuries to his/her teeth, mouth, head or jaws? Yes No

Please explain.....

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Medical History, Page 1 of 2

Pediatrician's name: ..... Phone: ( ) .....

1. May we have your permission to consult with this physician? Yes No

2. Please describe any medical conditions that are of present concern (surgeries, injuries, issues related to healthcare):

.....

3. Is the patient taking any medicines at this time? Yes No
Please List Medications:
.....

4. Has the patient ever been admitted to a hospital? Yes No

5. Has the patient ever received general anesthesia/sedation? Yes No

6. Is the patient allergic to any medicines? Yes No

If yes, please explain: .....

7. Is the patient allergic to any substances or foods? Yes No

If yes, please list allergy source(s): .....

8. Has the patient ever had a blood transfusion? Yes No

9. Has the patient ever been abused (physically, psychologically, sexually)? Yes No

Birth History

1. Full term birth Yes No

If no, please explain: .....

2. Complications Yes No

Please explain: .....

3. Is your child currently breastfed? Yes No

4. Is your child currently bottle fed? Yes No

(continued on next page)

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Medical History, Page 2 of 2

Please review the following groups of questions. Indicate if there is a current health problem, or if there was a problem in the past for your child.

Blood, Heart and Liver

Anemia	Yes	No
Hemophelia	Yes	No
Sickle Cell Anemia	Yes	No
Heart Problems	Yes	No
Heart Murmur	Yes	No
Hepatitis	Yes	No
AIDS/HIV/ARC	Yes	No
Rheumatic Fever		
Leukemia		

Other: .....

Eyes, Ears, Nose, Throat and Pulmonary Disorders

Eye Problems	Yes	No
Hearing Problems	Yes	No
Frequent Ear Infections	Yes	No
Asthma	Yes	No
Environmental Seasonal Allergies	Yes	No
Sinus Problems	Yes	No
Strong Gag Reflex	Yes	No
Cleft Lip/Cleft Palate	Yes	No
Tuberculosis	Yes	No
Pneumonia	Yes	No

Other: .....

Kidney, Bladder, Renal

Renal Disease	Yes	No
Frequent Infections	Yes	No

Other:

Endocrine and Glands

Diabetes	Yes	No
Thyroid Problems	Yes	No

Other: .....

Muscles and Nervous System

Cerebral Palsy	Yes	No
Convulsions/Seizures	Yes	No
Epilepsy	Yes	No
Spina Bifida	Yes	No

Other:

Bones

Orthopedic Problems	Yes	No
Scoliosis	Yes	No

Other: .....

Psychological and Emotional

ADHD/ADD	Yes	No
Autism/Spectrum Disorders/Asperger's	Yes	No
Down Syndrome	Yes	No
Brain Injury	Yes	No
Developmental Delay	Yes	No
Clinical Depression	Yes	No
Bipolar Disorder	Yes	No
Behavioral Issues	Yes	No

Other: .....

Adolescent/Teen Social Issues that Can Affect Dental Health

Pierced Lips/Tongue	Yes	No
Smoking	Yes	No
Alcohol	Yes	No
Eating Disorders	Yes	No
Substance Abuse	Yes	No
Oral Infections	Yes	No
Pregnancy	Yes	No

Other: .....

Signature: .....

Relationship to patient: .....

Print Name: .....
First Last

Date: .....
month/day/year

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