

pediatric dental center

professional corporation

29421 Ryan Road Warren, MI 48092 (586) 754-6300 www.PDConline.com



48621 Hayes Rd. Shelby Park, Bldg #500 Shelby Twp., MI 48315 (586) 247-5437 (KIDS) www.KSPDonline.com

PATIENT INFORMATION

CHILD'S FULL NAME:		NICK NAME:							
CHILD'S BIRTH DATE:			AGE:			SEX: (Circle) M F			
CHILD LIVES WITH: (Circle)	Both Parents	Mother	Father	Guardian	Grandparents				
CHILD'S HOME ADDRESS:			CITY:			Z I P:			
HOME PHONE:			cell p	ohone:					
EMAIL ADDRESS:			CHILI	D'S SS#:					
			E NUMBE d, neighbor, re	R - Emergen elative, etc.)	су				
Name:			Relationship to	Child:	P	hone:			
We appreciate the referral of pat		like to send a s		ou". Whom may we					
		PARE	ENT INFOF	RMATION					
Father's Full Name:			Mo	ther's Full Name:					
Father Employed By:			Mo	ther Employed By	:				
Social Security #:			Soc	cial Security #:					
Driver's License #			Dri	ver's License #:					
Employer Phone #:			Em	ployer Phone #: _					
Birth Date:			Biri	th Date:					
		ENTAL IN	SURANCE	INFORMATION	ON				
Insured Party's Name:			Re	lationship to Child:					
Employer:			Ins	urance Co.:					
Group #:			Ins	urance Phone #: _					
Contract #									
IF MORE THAN ONE INSURAN	ICE COVERAGE, PLE	ASE COMPLE	TE:						
Insured Party's Name:			Re	lationship to Child:					
Employer:			Ins	urance Co.:					
Group #:			Ins	urance Phone #: _					
Contract #:									

Payment for services is required at each appointment.

The adult who brings the child to the office is financially responsible.

Family Physician or Pediatrician:					_ ''	none:			
Date of Last Visit:	Pate of Last Visit: Are all immunizations up to date? (Circle) YES NO								
			MEDICAL HISTO	RY					
CONDITION	YES	NO	CONDITION	YES	NO	CON	ONDITION	YES	NO
ADHD / ADD (circle)			Cystic Fibrosis			Kidney Disorde	er		
AIDS or HIV Positive			Developmentally Impaired			Muscular Dystr	ophy		
Acid Reflux / GERD			Depression			Motor Skills De	•		
Artificial Prosthesis	_		Diabetes	_		Radiation Treat			
Asthma	-		Drug Allergy			Rheumatic Fev	ver		
Autism Bleeding Disorder / Anemia			Eating Disorder Epilepsy			Seizures Shunt			
Blood Transfusion			Hearing Impaired						
Brain / Nerve Damage	+		Heart Disorder / Surgery			Surgery	,u		
Cerebral Palsy			Heart Murmur			Tuberculosis			
Chemotherapy			Hepatitis / Liver Disorder			Vision Impaired	k		
Counseling			Hyperactivity			Other			
Please explain any YES answe	rs or ot	her h	ealth problems:						
Medical Specialists Name:						Phone:			
s your child taking any medicine now: (C	irc l e) Y	ES N	NO List:						
Any reaction to Anesthetic? Describe _s your child taking any medicine now: (Cs your child being seen by a physician? (Did your child receive fluoride treatment at the properties of the province of the prov	ircle) Y Circle) at pediat Circle) YES	ES N YES rician' YES NO	NO List: NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: When:	□ Other					
Any reaction to Anesthetic? Describe _s your child taking any medicine now: (C s your child being seen by a physician? (Did your child receive fluoride treatment a Does your child have a toothache now? (Any previous dental experience? (Circle) What was done:	ircle) Y Circle) at pediat Circle)	ES N YES rician' YES NO	NO List:NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction:	□ Other					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at the cost your child have a toothache now? (Any previous dental experience? (Circle) What was done: Child's reaction: Main dental concerns:	ircle) Y Circle) at pediat Circle) YES	ES N YES rician' YES NO	NO List: NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction:	□ Other					_
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at 200es your child have a toothache now? (Cos your child have a toothache now?)	rircle) Y Circle) at pediat Circle) YES	ES N YES rician' YES NO	NO List:NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction: When:	□ Other					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cost your child being seen by a physician? (Cost your child receive fluoride treatment at Does your child have a toothache now? (Any previous dental experience? (Circle) What was done: Child's reaction: Main dental concerns: Any injuries to front teeth? (Circle) YES Has your child ever had injuries to the he	ircle) Y Circle) at pediat Circle) YES	ES N YES rrician' YES NO	NO List:NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction: When: Circle) YES NO	□ Other					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child have a toothache now? (Cos your child have any oral habits? (Cos your child have any oral habits?)	ricle) Y Circle) at pediat Circle) YES NO ad or ne	ES N YES rrician' YES NO	NO List:NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction: When: Circle) YES NO Finger Pacifier Other:	□ Other					
Any reaction to Anesthetic? Describe s your child taking any medicine now: (C s your child being seen by a physician? (C) Did your child receive fluoride treatment at Does your child have a toothache now? (Any previous dental experience? (Circle) What was done: Child's reaction: Main dental concerns: Any injuries to front teeth? (Circle) YES Has your child ever had injuries to the he Does your child have any oral habits? (Circle) Who brushes your child's teeth?	ricle) Y Circle) at pediat Circle) YES NO ad or ne	ES NYES rrician' YES NO	NO List:NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction: When: Circle) YES NO Finger Pacifier Other: When:	□ Other					
Any reaction to Anesthetic? Describe s your child taking any medicine now: (C s your child being seen by a physician? (C) Did your child receive fluoride treatment a Does your child have a toothache now? (Any previous dental experience? (Circle) What was done:	ricle) Y Circle) at pediat Circle) YES NO ad or ne	ES N YES rician' YES NO	NO List:NO If yes, why	□ Other					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at 200es your child have a toothache now? (Cos your child have a toothache now? (Cos your child have a toothache now? (Cos your child experience? (Circle) What was done: Child's reaction: Any injuries to front teeth? (Circle) YES has your child ever had injuries to the head your child have any oral habits? (Circle) Who brushes your child's teeth?	ricle) Y Circle) at pediat Circle) YES NO ad or ne	ES N YES rician' YES NO	NO List:NO If yes, why DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction: When: Circle) YES NO Finger Pacifier Other: When:	□ Other					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at the cost your child have a toothache now? (Cost your child have a toothache now? (Cost your child have a toothache now? (Cost your child experience? (Circle) Any previous dental experience? (Circle) What was done: Child's reaction: Any injuries to front teeth? (Circle) YES Has your child ever had injuries to the hele your child have any oral habits? (Circle) Who brushes your child's teeth? Reason for today's appointment?	ricle) Y Circle) at pediat Circle) YES NO ad or ne	ES N YES rician' YES NO	NO List:NO If yes, why	□ Other					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at the cost your child have a toothache now? (Cost your child have a toothache now? (Cost your child have a toothache now? (Cost your child experience? (Circle) Any previous dental experience? (Circle) What was done: Child's reaction: Any injuries to front teeth? (Circle) YES Has your child ever had injuries to the hele your child have any oral habits? (Circle) Who brushes your child's teeth? Reason for today's appointment?	ricle) Y Circle) at pediat Circle) YES NO ad or ne rcle) Ti	ES NYES YES NO Ck? ((NO List:NO If yes, why	□ Other RY					
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child have a toothache now? (Cos your child seed to your child experience? (Circle) Any injuries to front teeth? (Circle) YES has your child ever had injuries to the help your child have any oral habits? (Circle) Yes has your child have any oral habits? (Circle) Yes has your child have any oral habits? (Circle) Yes has your child have any oral habits? (Circle) Yes has your child have any oral habits? (Circle) Yes had any oral habits?	ricle) Y Circle) at pediat Circle) YES NO ad or ne rcle) Ti	ES NYES rician' YES NO ck? (C	NO List:NO If yes, why	□ Other RY RY r Filtel	red W	ater			
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at the cost your child have a toothache now? (Cony previous dental experience? (Circle) What was done: Child's reaction: Child's reaction: Any injuries to front teeth? (Circle) YES has your child ever had injuries to the heacton your child have any oral habits? (Circle) Who brushes your child's teeth? Reason for today's appointment? Name and ages of other children in the heacton you have fluoride in your drinking water.	NO ad or ne rcle) TI busehold rer? (Circle)	ES NYES YES NO Ck? ((Chinumb	NO List:NO If yes, why	□ Other RY r Filter	rred W	ater			
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at the Does your child have a toothache now? (Cony previous dental experience? (Circle) What was done: Child's reaction: Any injuries to front teeth? (Circle) YES that your child ever had injuries to the hereoes your child have any oral habits? (Circle) Who brushes your child's teeth? Reason for today's appointment? Do you have fluoride in your drinking water ones your child snack frequently? (Circle) your child drink juice frequently? (Circle)	NO ad or ne rcle) Ti	ES NYES rician' YES NO ck?(Chumb	NO List:NO If yes, why	Q Other RY r Filter	red W	ater			
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment a goes your child have a toothache now? (Cos your child have a toothache now? (Cos your child experience? (Circle) What was done: Child's reaction: Any injuries to front teeth? (Circle) YES has your child ever had injuries to the head your child have any oral habits? (Circle) Who brushes your child's teeth? Beason for today's appointment? Name and ages of other children in the head your child snack frequently? (Circle your child drink juice frequently? (Circle your child your child your drinking water your child drink juice frequently? (Circle your child your ch	NO ad or ne rcle) TI busehold rer? (Circle) YES	ES NYES rician' YES NO ck? ((Chumb) NO ES 1	DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: When: Parent's reaction: When: Circle) YES NO Finger Pacifier Other: When: DIETARY HISTOF YES NO City Water Bottle Wate On what? NO What kind? es have natural acids which can cause	□ Other RY RY r Filter e cavitie	red W	ater sen frequently.			
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment at 200es your child have a toothache now? (Cos your child have a toothache now? (Cos your child have a toothache now? (Cos your child experience? (Circle) and the properties of the prop	NO ad or ne role) Ti ousehold er? (Circle) YES ircle) YES	ES NYES rician' YES NO ck? (C numb NO res NO YES YES	DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: Parent's reaction: Circle) YES NO Finger Pacifier Other: When: DIETARY HISTOF YES NO City Water Bottle Wate On what? NO What kind? es have natural acids which can cause NO Explain:	RY RY r Filter	red W	ater			
Any reaction to Anesthetic? Describe so your child taking any medicine now: (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child being seen by a physician? (Cos your child receive fluoride treatment a goes your child have a toothache now? (Cos your child have a toothache now? (Cos your child experience? (Circle) What was done: Child's reaction: Any injuries to front teeth? (Circle) YES has your child ever had injuries to the head your child have any oral habits? (Circle) Who brushes your child's teeth? Beason for today's appointment? Name and ages of other children in the head your child snack frequently? (Circle your child drink juice frequently? (Circle your child your child your drinking water your child drink juice frequently? (Circle your child your ch	NO ad or ne rcle) TI busehold rer? (Circle) YES many frui (Circle) permiss	ES NYES rician' YES NO ck? ((Chumb) Hele) Y NO FES NO YES Sion is	DENTAL HISTOF ? (Circle) YES NO Date: NO Where: Where: When: Parent's reaction: When: Circle) YES NO Finger Pacifier Other: When: DIETARY HISTOF ?ES NO City Water Bottle Wate On what? NO What kind? es have natural acids which can caus NO Explain: s required from a parent or guardia.	☐ Other RY RY r Filter e cavitie	s if tal	ater sen frequently.			

SUPPLEMENTAL HISTORY QUEST			NEA NIT/TOI	DDI ED			
Was your child born prematurely?	□ YES						
·			II ILO, WIIALV	veek:			
What was your child's birth weight?			□ 0 ddth		741	□ 40,00 ·····th	
How long was your child breast-fed?	□ N/A	□<6mths	☐ 6-11 mths	☐ 12 - 1			☐ 2 yrs or more
How long was your child bottle-fed?	□ N/A	□ <6mths	☐ 6-11 mths	□ 12-1	/ mths	☐ 18-23 mths	☐ 2 yrs or more
Do/did you feed your child infant formula?	☐ YES	□NO	If YES, what	type?		☐ Ready to use	
						☐ Liquid Conce	
Does/did your child sleep with a bottle?	☐ YES	□NO	If YES, conter	nt of bottle	?		
Does/did you child us a no-spill training cup?	☐ YES	□NO					
Child's age (in months) when first tooth appeared	I in mouth						
Has your child experienced any teething problem	s?	□YES	□NO				
When did you begin brushing his/her teeth?	□ N/A	□<6mths	☐ 6-11 mths	□ 12 - 1	7 mths	☐ 18-23 mths	☐ 2 yrs or more
When did you begin using toothpaste?	□ N/A	□<6mths	☐ 6-11 mths	□ 12-1	7 mths	☐ 18-23 mths	☐ 2 yrs or more
Who is your child's primary care taker during the	day?		During t	he evenin	g?		
Name/age of siblings at home:							
							_
Signature of Parent/Guardian - Relationship to Child		Date			f Stoff Mo	ember Reviewing H	ictory
• • • • • • • • • • • • • • • • • • •				olynature o			
SUPPLEMENTAL HISTORY QUEST	TIONS F	OR AN A	DOLESCE	NT PAT	TENT	(12 YRS AN	D UP)
Do you have any concerns about your mouth, teeth, or oral health?	□ YES	□NO	If YES, descril	be			
Have you recently experienced any dental/oral pain?	□YES	□NO	If YES, descril	be			
Do you bleach your teeth?	☐ YES	□NO	If YES, how of	ften			
Have there been any recent changes in your dietary habits?	□YES	□NO	If YES, descril	be			_
Are you taking any dietary or herbal supplements?	- V						
• •	☐ YES	□NO	If YES, descril	be			
Do you participate in contact sports or high speed sports (skiing, motorcycles)?	□ YES						
	☐ YES ertain beha we use to nt might b	□ NO aviors/activition treat oral contents of using. The	If YES, descriles that can have nditions may in the fore, we enco	be e significa teract with ourage our	nt conse n drugs (_l r adolesc	equences on their prescription, ove eent patients to a	r oral health and/ r-the-counter, nswer all of
high speed sports (skiing, motorcycles)? We recognize that patients may engage in ce or general health. In addition, medicines that or recreational) and other substances a patie the following questions truthfully. If you prefer	☐ YES ertain beha we use to nt might b	□ NO aviors/activition treat oral contents of using. The	If YES, descriles that can have nditions may in the fore, we enco	be e significa teract with ourage our	nt conse n drugs (_l r adolesc	equences on their prescription, ove eent patients to a	r oral health and/ r-the-counter, nswer all of
high speed sports (skiing, motorcycles)? We recognize that patients may engage in ce or general health. In addition, medicines that or recreational) and other substances a patie the following questions truthfully. If you prefer dentist.	☐ YES ertain beha we use to nt might b r not to an	□ NO aviors/activitie treat oral co e using. The swer an item	If YES, descriles that can have nditions may in the fore, we enco	be e significa teract with ourage our	nt conse o drugs (_l o adolesc s any co	equences on their prescription, ove eent patients to a	r oral health and/ r-the-counter, nswer all of tially with your
high speed sports (skiing, motorcycles)? We recognize that patients may engage in coor general health. In addition, medicines that or recreational) and other substances a patient the following questions truthfully. If you prefer dentist. Do you have any history of:	☐ YES ertain beha we use to nt might b r not to an	□ NO aviors/activitie treat oral co e using. The swer an item th, etc.)	If YES, descriles that can have nditions may in refore, we enco	be e significa teract with ourage our will discus	nt conse drugs (p dolesc s any co	equences on their prescription, ove tent patients to a ncerns confident	r oral health and/ r-the-counter, nswer all of iially with your
high speed sports (skiing, motorcycles)? We recognize that patients may engage in ce or general health. In addition, medicines that or recreational) and other substances a patie the following questions truthfully. If you prefer dentist. Do you have any history of: Oral habits (chewing fingernails, clenching/gr	☐ YES ertain beha we use to nt might b r not to an	□ NO aviors/activitie treat oral co e using. The swer an item th, etc.)	If YES, descriles that can have nditions may in refore, we encorring, we hope you	be e significa teract with ourage our will discus	nt conse n drugs (j n adolesc s any co	equences on thei prescription, ove ent patients to a ncerns confident	r oral health and/ r-the-counter, nswer all of tially with your SWER
high speed sports (skiing, motorcycles)? We recognize that patients may engage in ce or general health. In addition, medicines that or recreational) and other substances a patie the following questions truthfully. If you prefer dentist. Do you have any history of: Oral habits (chewing fingernails, clenching/gr Tobacco use (cigarette, pipe, cigar, bidi, snuff	☐ YES ertain beha we use to nt might b r not to an	□ NO aviors/activitie treat oral co e using. The swer an item th, etc.)	If YES, descriles that can have nditions may in refore, we encory, we hope you	be e significa teract with ourage our will discus \textsquare NO	nt conse drugs (p adolesc s any co	equences on their prescription, ove cent patients to a incerns confident FER NOT TO AN	r oral health and/ r-the-counter, nswer all of iially with your SWER SWER
high speed sports (skiing, motorcycles)? We recognize that patients may engage in ce or general health. In addition, medicines that or recreational) and other substances a patie the following questions truthfully. If you prefer dentist. Do you have any history of: Oral habits (chewing fingernails, clenching/gr Tobacco use (cigarette, pipe, cigar, bidi, snuff Eating disorder (anorexia, bulimia, etc.)	□ YES ertain beha we use to nt might b r not to an inding tee f, spit, che	□ NO aviors/activitie treat oral co e using. The swer an item th, etc.)	If YES, descriles that can havenditions may interfere, we encounty, we hope your YES	be e significa teract with ourage our will discus NO NO	nt conse of drugs (of adolesce s any co PREF PREF PREF	equences on their prescription, ove eent patients to a ncerns confident FER NOT TO AN FER NOT TO AN	r oral health and/ r-the-counter, nswer all of tially with your SWER SWER SWER
high speed sports (skiing, motorcycles)? We recognize that patients may engage in coor general health. In addition, medicines that or recreational) and other substances a patie the following questions truthfully. If you prefer dentist. Do you have any history of: Oral habits (chewing fingernails, clenching/gr Tobacco use (cigarette, pipe, cigar, bidi, snuff Eating disorder (anorexia, bulimia, etc.) Oral piercings/jewelry (including grill)	□ YES ertain beha we use to nt might b r not to an inding tee f, spit, che	□ NO aviors/activitie treat oral co e using. The swer an item th, etc.)	If YES, describes that can have nditions may in refore, we encory, we hope you a YES YES YES	be e significa iteract with ourage our will discus NO NO NO	nt conse drugs (p adolesc s any co	equences on their prescription, over the patients to a confident of the patients to a confident of the patients of the patient	r oral health and/ r-the-counter, nswer all of iially with your SWER SWER SWER SWER

Signature of Mom, Dad or Legal Guardian (Circle one)

Date

Would you like to discuss a referral to a family dentist or general dentist because of your age?

□ YES

Signature of Staff Member Reviewing History

 \square NO