Pediatric Dentistry of Spartanburg & Gaffney

Patient Name Birth Date:

Child's Physician ______ City/State ______ Phone ______

Date of last physical examination ______ Results ______

Do you have any dental concerns for today's visit? ❍Yes ❍No If yes ______

Has your child had any injuries to mouth, teeth or head? ❍Yes ❍No If yes ______

Does your child brush daily? ❍Yes ❍No

Does your child floss daily? ❍Yes ❍No

Any habits such as thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, grinding, etc.? ______

Any sensitivity to heat, cold, pressure, sweets, or other? ______

Has child's parent or sibling worn braces or had any dental abnormalities such as missing, extra, impacted teeth, tumors or cysts of the jaws, deformed or discolored teeth? ______

Is your child under the care of a physician now? ❍Yes ❍No If yes ______

Has your child evern been hospitalized or had a major operation? ❍Yes ❍No If yes ______

Is your child taking any medications or drugs? ❍Yes ❍No If yes ______

Does your child have abnormal bleeding problems? ❍Yes ❍No If yes ______

Does your child have any allergies to any of the following?

❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic

❒ Metal ❒ Latex ❒ Sulfa Drugs ❒ Local Anesthetics

❒ NONE

Other? ❒ If yes ______

Does your child have, or have they ever had any of the following?

AIDS/HIV Positive	❍Yes	❍No	Radiation Treatments	❍Yes	❍No	Diabetes	❍Yes	❍No	Hepatitis A	❍Yes	❍No
Drug/Alcohol Abuse	❍Yes	❍No	Hepatitis B or C	❍Yes	❍No	Anemia	❍Yes	❍No	Herpes	❍Yes	❍No
Rheumatic Fever	❍Yes	❍No	Epilepsy or Seizures	❍Yes	❍No	Artificial Heart Valve	❍Yes	❍No	Mononucleosis	❍Yes	❍No
Hives or Rash	❍Yes	❍No	Sickle Cell Disease	❍Yes	❍No	Asthma	❍Yes	❍No	Mumps	❍Yes	❍No
Measles	❍Yes	❍No	Sinus Trouble	❍Yes	❍No	Blood Disease	❍Yes	❍No	Frequent Cough	❍Yes	❍No
Kidney Problems	❍Yes	❍No	Spina Bifida	❍Yes	❍No	Leukemia	❍Yes	❍No	Stomach/Intestinal Disease	❍Yes	❍No
Breathing Problems	❍Yes	❍No	Liver Disease	❍Yes	❍No	Low Blood Pressure	❍Yes	❍No	Cancer	❍Yes	❍No
Thyroid Disease	❍Yes	❍No	Chemotherapy	❍Yes	❍No	Chicken Pox	❍Yes	❍No	Cerebral Palsy	❍Yes	❍No
Heart Attack/Failure	❍Yes	❍No	Tuberculosis	❍Yes	❍No	Cold Sores/Fever Blisters	❍Yes	❍No	Heart Murmer	❍Yes	❍No
Pain in Jaw Joints	❍Yes	❍No	Congenital Heart Disease	❍Yes	❍No	Ulcers	❍Yes	❍No	Convulsions	❍Yes	❍No
Heart Trouble/Disease	❍Yes	❍No	Autism	❍Yes	❍No	ADHD	❍Yes	❍No			

Has your child ever had any serious illness not listed above? ❍Yes ❍No If yes ______

Does your child have any special needs? ❍Yes ❍No If yes ______

Has your child ever had a blood transfusion? ❍Yes ❍No

Do you have City or Well Water at your current address? ______

Please complete the following questions if you are a New Patient:

How did you hear about our office? ______

Name of previous Dentist ______ Date of last visit to a dentist ______

What service was child seen for? ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X ______ **Date:** ______