Bloomington Pediatric Dentistry

Welcome to our practice!
We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child good oral habits, which will keep their smile beautiful for their lifetime.

Child's Name	Parent / Guardian information
______________________________ Last First MI	Name______________________________
Child's Nickname______________________________	Relationship______________________________
Child's Birth date__________ Age______ Sex__________	Home Address______________________________
Home Address______________________________	City________________ Zip________________
City________________ Zip________________	Home Phone# ____________ Cell____________
Home Phone # ______________________________	SSN#________________ DOB________________
Cell Phone # ______________________________	Employer______________________________
Alternate Contact________________ Phone__________	Work Phone #______________________________
Names of other children in family________________	Email Address______________________________
Referred by ______________________________	Parent's Marital Status: Married Divorced Separated Widowed Single Remarried
Primary Dental Insurance	Secondary Dental Insurance
CO Name______________________________	CO Name______________________________
Address______________________________	Address______________________________
Phone#________________ Insured ID#________________	Phone#____________ Insured ID#____________
Group#______________ Insured's Name______________	Group#______________ Insured's Name__________
Relation__________________ DOB______________	Relation__________________ DOB__________
Insured Employer______________________________	Insured Employer______________________________
SSN# ______________________________	SSN# ______________________________

Child's Physician

____

City/State______________ Phone#________________

Date of last exam____________ Results ____________

Health History

Has your child ever had any of the following:

AIDS/HIV ____________
Anemia ____________
Asthma ____________
Autism ____________
Bladder Problems ____________
Cancer ____________
Cerebral Palsy ____________
Congenital Birth Defects ____________
Convulsions/Fainting ____________
Diabetes ____________
Epilepsy ____________
Eating Disorder ____________
Speech/Hearing Problems ____________
Heart Problems/Murmur ____________
Hepatitis ____________
Mouth Breather ____________
Pregnant ____________
Prolonged Bleeding/Bruises easily ____________
Psychological/Emotional Problems ____________
Rheumatic Fever ____________
Sinus Problems ____________
Tuberculosis ____________
Allergies ____________

____

Do you consider your child to be

Advanced in the learning process ____________
Progressing normally ____________
Slow in the learning process ____________

Please explain any medical problems your child has/ had or any medications currently taking____________

____
____
____

Date of the last dental visit______________________

Previous Dentist____________________________

Has your child had any difficulty with previous dental visits?____

____

Have there been any injuries to teeth, face, or mouth?

____
____

Why did you bring your child to the dentist today?____

____
____

Is your child breastfed? Yes/No Until what age______

Does your child still take a bottle or a sippy cup? Yes/No

What is your child's favorite fluid to drink? Water, Kool-aid, Apple juice, Other Juice, Milk, Formula, Tea, Soft drink, Sports drinks, or other

How often does your child brush?__________________

Do you help w/ brushing?______________________

How often does your child floss?__________________

Is child's water fluoridated?____________________

Does your child:

Suck thumb or finger ____________
Bite/suck lips ____________
Bite/chew nails ____________
Grind teeth ____________
Clench jaws ____________
Chew hard objects ____________
Use a pacifier ____________

Parent/Guardian Signature and date

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