tinker tooth
PEDIATRIC DENTISTRY

## Patient Information

Child's Full Name: _____ Goes by: _____ ○ Male ○ Female
Date of birth: _____ Age: _____
Address: _____ City/State: _____ Zip Code: _____
Phone Number: (  ) _____ ○ Home ○ Mobile

Current School: _____ Grade: _____
Hobbies/Interest: _____
Please list any other siblings seen in our office: _____
Whom Should we thank for referring you? _____

## Parent/Legal Guardian (LG) Information

**Parent/LG Name**: _____ Relation to Patient: _____
Date of Birth: _____ SSN: _____ Address: ○ Same As Above
(If different, please indicate alternative address) _____
City/State: _____ Zip Code: _____
Best Contact Number: (  )_____ ○ Home ○ Mobile ○ Work
Employer: _____ Work Number: (  ) _____
Primary E-Mail: _____

**Parent/LG Name**: _____ Relation to Patient: _____
Date of Birth: _____ SSN: _____ Address: ○ Same As Above
(If different, please indicate alternative address) _____
City/State: _____ Zip Code: _____
Best Contact Number: (  )_____ ○ Home ○ Mobile ○ Work
Employer: _____ Work Number: (  ) _____
Primary E-Mail:
_____

## Dental Insurance

1. Policy Holder: _____ Insurance Company: _____
   SSN: _____ DOB: _____ Group Number: _____ID Number: _____

2. Policy Holder: _____ Insurance Company: _____

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SSN: _____ DOB: _____ Group Number: _____ID Number:_____

## Emergency Contact Information (Other than Parents/LG)

Contact Name: _____ Relationship to Patient: _____
Phone Number: (  ) _____ ◯Home ◯ Mobile

Contact Name: _____ Relationship to Patient: _____
Phone Number: (  ) _____ ◯Home ◯ Mobile

## Medical History

Pediatrician/Primary Medical Doctor / Phone Number: _____
Please list any other specialist(s) your child is seeing: _____
Is your child current on their immunizations? Yes ◯ No ◯
Please list any medications that your child is taking: _____
Please list any supplements/vitamins that your child is taking: _____
Please list any allergies your child has (including medications, food, latex, other): _____
Does your child require a premedication antibiotic prior to dental treatment (i.e., heart defect etc.)? Yes ◯ No ◯
Has your child had any change in family emotional history? (i.e., loss of pet, new school)_____

- ◯ ADHD/ADD
- ◯ Immune Disorder/HIV/AIDS
- ◯ Asthma/Respiratory Disease
- ◯ Autism Spectrum Disorder
- ◯ Cerebral Palsy
- ◯ Cancer/tumor
- ◯ Epilepsy/Seizures
- ◯ Cleft Lip/Palate
- ◯ Hepatitis/Liver Disease
- ◯ Diabetes (Type___)
- ◯ Developmentally Delayed
- ◯ Sickle Cell Anemia/Trait
- ◯ Speech Disorder
- ◯ Eye/Vision Issues
- ◯ Hearing Impairment
- ◯ Heart Murmur/defect/surgery
- ◯ Tuberculosis
- ◯ Kidney Disease
- ◯ Sleep Apnea
- ◯ Hemophilia/Bleeding Disorder
- ◯ Anemia
- ◯ Metabolic Disorder
- ◯ Stomach/GI disorders
- ◯ Acid Reflux
- ◯ Psychiatric Care
- ◯ Premature Birth
- ◯ Genetic Syndrome/Disorder
- ◯ Cold Sores/Canker Sores
- ◯ Eating Disorder
- ◯ Implants/Shunts/Pins
- ◯ Bone/Joint/Muscle Problems
- ◯ Anxiety/Depression
- ◯ Sensory Issues

Please List Any Surgeries or Hospitalizations: _____
_____
Additional Medical Information: _____

## Dental History

◯Y ◯ N Is this your child's first visit to the dentist?
Previous Dentist: _____
Date of Last Visit: _____

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Y N Were any x-rays taken at last visit?
Y N Have any cavities been noted in the past?
Y N Has your child ever experienced dental trauma? (i.e., chipped tooth, falls, lost tooth)
Y N Has your child ever received local anesthetic?
Y N Has your child experienced any unfavorable reaction from previous dental or medical care?
If yes, please provide explanation: _____
Y N Has your child ever been hospitalized, sedated, and/or undergone any surgery?
Y N Has your child ever received nitrous oxide (laughing gas), oral sedation, or general anesthesia to complete dental work? If so, were there any complications?

_____

## Oral Habits

Does your child currently:

- Breastfeed At what age stopped: _____
- Bottle Feed At what age stopped: _____
- Thumb/finger suck
- Use pacifier
- Bite nails
- Grind Teeth
- Mouth Breath
- Tongue Thrust
- Snore

How often does your child brush? M only M only M and PM

Y N Does your child floss?
Y N Is assistance provided with brushing and flossing?
Y N Does your child drink juice/soda? If so, how much a day? _____
Y N Does your child snack frequently throughout the day? How often? _____
Y N Does your child take a cup or bottle to bed?
Y N Does your child take gummy vitamins?
Y N Does your child use a fluoride toothpaste?

Does your child receive:

- Tap water
- Bottled water
- Well water

Purpose of Today's Visit: _____

To the best of my knowledge, the answers I have given are accurate. I understand that it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

PARENT/ LG SIGNATURE: _____ DATE: _____

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# CONSENT FOR DENTAL TREATMENT

I am the parent and/or legal guardian of the patient and there are no court orders in effect preventing me from giving consent. I confirm that the information provided above is accurate to the best of my knowledge. I provide authorization for Tinker Tooth Pediatric Dentistry to perform any necessary dental services including, but not limited to, a comprehensive examination, cleaning, fluoride treatment, and any necessary dental treatment to maintain my child's oral health. I have been advised that x-rays may be necessary to properly diagnose dental disease and detect pathology. I have an expectation that risks and benefits for all dental treatment will be explained. I understand the most common dental complications include, but are not limited to, pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth or surrounding tissues, development of a temporomandibular disorder, temporary or permanent numbness, and allergic reactions.

PARENT/LG SIGNATURE: _____DATE:_____

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