510 Pellis Road
Greensburg, PA 15601
(724) 832-2255

Complete this form and bring it on your child's first scheduled appointment.

Child's Name ______________________ DOB ____________ M/F ________ Weight ________

Child's Address ____

School ____

Family Dentist ______________________ Referred By ______________________

Father (or Legal Guardian) ______________________	Mother ______________________
Address ______________________	Address ______________________
______________________	______________________
Home Phone ______________________	Home Phone ______________________
Cell Phone ______________________	Cell Phone ______________________
Email ______________________	Email ______________________
Employer ______________________	Employer ______________________
Work Phone ______________________	Work Phone ______________________
Dental Ins. ______________________	Dental Ins. ______________________
Your DOB ______________________	Your DOB ______________________
SS# or Agreement # ______________________	SS# or Agreement # ______________________
Group# ______________________	Group# ______________________

Who has primary responsibility for this account? ______________________

Child's Name ______________________ Nick Name ______________________

DENTAL HISTORY

Is your child having any dental problems? ☐Y ☐N Explain ______________________

Has your child been to the dentist before? ☐Y ☐N Last Visit ______________ Where ______________

Has your child had x-rays taken before? ☐Y ☐N When ______________ Where ______________

Has your child had any dental injuries? ☐Y ☐N Explain ______________________

What habits does your child have that might affect the teeth or mouth?

☐ Mouth breather ☐ Grinding teeth ☐ Finger ☐ Sucking thumb ☐ Pacifier

Other ______________________

Does your child take Fluoride Vitamins? ☐Y ☐N What kind? ______________ Dose? (.25, .5, 1.0) ______________

Diet Summary ______________________

General Dental history of family ______________________

Does your child brush his own teeth? ☐Y ☐N If not, who does? ______________ How often? ______________

Did your child sleep with bottle? ☐Y ☐N What did it contain? ______________________

When did he or she stop? ______________________

MEDICAL HISTORY

Is your child in good health now? ☐Y ☐N Explain ______________________

Does your child have any allergies to food or drugs? ☐Y ☐N Specify ______________________

Warned against any drugs? ☐Y ☐N Specify ______________________

Are your child's immunizations up to date? ☐Y ☐N Specify ______________________

Is your child taking medication? ☐Y ☐N Specify ______________________

Were there problems during pregnancy? ☐Y ☐N Explain ______________________

____

Ages of brothers and sisters ______________________

Has your child been hospitalized? ☐Y ☐N When? ______________________

Where? ______________ For What? ______________________

Has your child had any of the following?

☐ Cardiac/Heart disease or defects	☐ Diabetes	☐ Blindness
☐ Rheumatic Fever	☐ AIDS	☐ Speech problems
☐ Kidney disease	☐ Dizziness/Fainting	☐ Hearing problems
☐ Hepatitis/Liver disease	☐ Anemia	☐ Birth defects
☐ Convulsions/Seizures	☐ Cerebral Palsy	☐ Emotional problems
☐ Asthma/Breathing difficulties	☐ Cleft Lip/Palate	☐ Blood Transfusion
☐ Hemophilia/Bleeding Disorders	☐ Down's Syndrome	☐ Cancer
☐ Autism Spectrum Disorder	☐ Mental Retardation	☐ Other (explain below).

If Other, please explain ______________________

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Who is your child's pediatrician/physician? ______________________

Any additional information ______________________

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Signature ______________________ Date ______________________