Poiset and Associates
Pediatric Dentistry and Orthodontics

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Please Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nick Name: _____ ☐Male ☐Female

Child's Date of Birth: _____/_____/_____ Child's Age: _____

Attends What School? _____

Is your child adopted? ☐Yes ☐No Does the child know? ☐Yes ☐No

Brother's names & ages: _____

Sister's names & ages: _____

Dental History

	Yes	No
Is this the child's first visit to the dentist?	☐	☐
Any unfavorable experiences in another dental office?	☐	☐
Are there any specific concerns about the child's mouth or teeth?	☐	☐

Please describe further, if necessary: _____

How many times per day are the child's teeth brushed?

☐0 ☐1 ☐2 ☐3

Are the child's teeth flossed daily?	☐	☐
Does an adult assist with brushing and flossing the child's teeth?	☐	☐
Is fluoride toothpaste used?	☐	☐
Does the child use any additional fluoride products?	☐	☐

☐Rinse ☐Gel ☐Water ☐Tablets or Drops

Has the child had or does the child need orthodontic treatment?	☐	☐
Does the child currently nurse?	☐	☐
Does the child currently use a bottle or sippy cup?	☐	☐
If yes, does the child have the bottle or sippy cup in bed?	☐	☐
Any TMJ pain or symptoms(clicking, popping, limited opening)?	☐	☐
Has the child had any injuries to the mouth or face?	☐	☐

If yes, please describe: _____

Does the child have any of the following habits?

Yes	No		Yes	No	
☐	☐	Pacifier Use	☐	☐	Grinds Teeth
☐	☐	Thumb or Finger Sucking	☐	☐	Bites Nails
☐	☐	Lip Sucking or Licking	☐	☐	Tongue Thrust

Health History

	Yes	No
Has the child ever had a serious illness?	☐	☐
Has the child ever been hospitalized?	☐	☐
Has the child ever had surgery?	☐	☐
Does the child have a syndrome or genetic disorder?	☐	☐
Any congenital birth defects or craniofacial defects?	☐	☐
Any physical or mental disabilities?	☐	☐
Is the child on the autistic spectrum?	☐	☐

Has the child had a history of, or condition related to the following?

Yes	No		Yes	No	
☐	☐	Congenital Heart Defect	☐	☐	Developmental Delay
☐	☐	Lung Disease	☐	☐	Speech Delay
☐	☐	Kidney Disease	☐	☐	Hyperactive / ADD
☐	☐	Liver Disease/Hepatitis	☐	☐	Sensory Integration
☐	☐	Endocrine System	☐	☐	Vision Impairment
☐	☐	Diabetes	☐	☐	Hearing Impairment
☐	☐	GI Disease	☐	☐	Seizures or Epilepsy
☐	☐	Acid Reflux / GERD	☐	☐	Premature Birth
☐	☐	Celiac or Irritable Bowel	☐	☐	Cerebral Palsy
☐	☐	Hemophilia/Bleeding Disorder	☐	☐	High Fevers
☐	☐	Blood Disorder	☐	☐	Ear infections
☐	☐	Anemia	☐	☐	Sinus Infections
☐	☐	Cancer or Tumors	☐	☐	Eczema
☐	☐	Leukemia	☐	☐	Skin Disorder
☐	☐	HIV+ / AIDS	☐	☐	Tuberculosis (TB)

Please discuss medical conditions further, if necessary: _____

Please list all allergies (medications, foods, latex): _____

Please list any medications the child is taking: _____

Does the child have any of the following breathing issues?

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Enlarged Tonsils/Adenoids
☐	☐	Environmental Allegies	☐	☐	Sleep Apnea
☐	☐	Snoring	☐	☐	Trouble Breathing Thru Nose

Child's Physician: _____

Phone Number: (_____) _____

I understand that, the information I have given on this form is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may require.

Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**

Dentist's Review	Update	Update	Update	Update	Update
Signature Date	Signature Date	Signature Date	Signature Date	Signature Date	Signature Date