



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?
- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiac/Heart disease or defects | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> AIDS | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Hepatitis/Liver disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Asthma/Breathing difficulties | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Hemophilia/Bleeding Disorders | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Intellectual Disabilities | <input type="checkbox"/> Other (explain below). |

If Other, please explain _____

Who is your child's pediatrician/physician? _____

Any additional information _____

Signature _____

Date _____