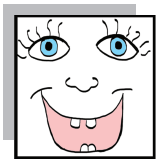
Kid's Smiles, inc



Lorraine Lewis, D.D.S.
Pediatric Dentist

107 North Street • Hyannis, MA 02601
Phone (508) 771-0920 • Fax (508) 771-2569
Specialist in dentistry for children & adolescents

Please complete and bring to 1st visit

Reviewed by
Dr. Date

PEDIATRIC PATIENT INFORMATION & HEALTH HISTORY FORM

Child's Name _____ Nickname_____D.O.B._____

Mailing Address: Street _____ Place of Birth _____

City _____ State _____ Zip_____Tel. #_____ Cell #_____

Mother's Name _____Occupation _____ Bus. Tel. # _____

Father's Name_____Occupation _____ Bus. Tel. # _____

Billing Address: Street _____

(if different than above) City_____ State _____ Zip_____

Marital Status: ___Married ___Single ___Separated ___ Divorced ___Widowed ____ Other

Child Lives With: ___ Both Parents ___ Mother ___ Father ___ Other

E-mail Address:_____

Child's Physician _____

Street _____ Tel. # _____

City _____ State _____ Zip _____

Pharmacy Name_____

Address_____ City _____

Child's Previous Dentist _____

Names and Ages of Siblings _____ D.O.B. _____

_____D.O.B. _____

Whom may we thank for referring you?_____

_____

Whom may we contact in case of emergency?

Name _____Relationship _____ Tel # _____

General Information

Who is accompanying the child today?

Name: _____ Relation:_____

Do you have custody of this child or are you the legal guardian?

☐ Yes ☐ No

DENTAL HEALTH HISTORY

Reason(s) for seeking dental care:

_____ First examination _____ Appearance of teeth _____ 2nd Opinion
_____ Routine Check-up _____ Crowding of teeth _____ Consultation
_____ Toothache or swelling _____ Accident _____ Orthodontic Eval.
_____ Other _____

If your child has been to a dentist previously,

When was the last visit? _____

Have x-rays been taken and when? Date _____ Y N

How did your child react and describe his/her temperament? _____

_____

Has your child had local anesthetic ("Novacaine")? _____

Were there any complications? _____

How do you think your child will react to dental treatment? _____

_____

_____

Has your child had fluoride in any of the following forms?

Fluoride tablets or fluoride in multi-vitamins Y N
Drinking water (community water fluoridation) Y N
Professional topical application Y N

Does your child brush his/her own teeth? Y N

How frequently and when A.M. _____ P.M. _____

After Breakfast _____ Snack _____ Before Bed _____

Do you assist in brushing your child's teeth? When?_____ Y N

Do you or your child use dental floss in cleaning their teeth? Y N

What kind of toothbrush does he or she use? _____ Hard Soft

Does your child snack frequently? Y N

If yes, what do those snacks usually consist of? _____

Have your child's teeth ever been injured? Y N

When? (Age) _____

Which teeth? _____

Cause? _____

Did he/she receive treatment? Y N

If yes, describe treatment _____

Does your child have any of the following habits? (Indicate inclusive ages)

Bottle with milk/juice to sleep or nap Y N
Thumb sucking Y N
Finger sucking Y N
Pacifier sucking Y N
Mouth breathing Y N

Has your child received any unusual dental or surgical treatment to the mouth? Y N

If yes, describe _____

MEDICAL HISTORY

Were there any difficulties during the pregnancy, delivery (e.g. prematurity), or first year of your child's life? Y N

If yes, describe _____

Is a physician currently treating your child for a specific illness? Y N

If yes, for what reason? _____

Is your child currently taking any medications? Y N

Drug	Reason

Has your child taken any unusual medications in the past? Y N

If yes, what and why? _____

Has your child had any allergic reactions to

Medications or drugs? _____

Foods? _____

Other? _____

Has your child ever been hospitalized? Y N

If yes, when and where? _____

Reason for hospitalization? _____

Has your child had any surgery (operations)? Y N

Date(s) and Age(s)? _____

For what reason(s)? _____

Was general anesthesia used? Y N

Were there any complications? _____

Are your child's immunizations current? Y N

Does your child have any history of the following diseases or conditions? Y N

- ☐ Abuse (Physical or Sexual)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding (prolonged)
- ☐ Brain Injury
- ☐ Cancer: Type _____
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Diabetes
- ☐ Emotional Disability
- ☐ Fainting (often)
- ☐ Gastrointestinal Disorders
- ☐ Hearing Loss: Type _____
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ HIV Infection (AIDS)
- ☐ Learning Disability
- ☐ Kidney Disease
- ☐ Leukemia: Type _____
- ☐ Mental Retardation
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Rheumatic Fever
- ☐ Transfusion of Blood
- ☐ Seizures
- ☐ Sickle Cell Trait or Disease
- ☐ Snoring (Sleep Apnea)
- ☐ Speech Prob.: Type _____
- ☐ Spina Bifida
- ☐ Syndrome: Type _____
- ☐ Other _____

Further Description or Remarks _____

Kids Smiles Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, bu acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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