Metro Dentalcare

# Metro Dentalcare Pediatrics

## Registration

Patient's Name _____ DOB _____
Name child would like to be called _____ Age _____ Gender M/F
Home Phone _____ Email _____
Home Address _____
Street City State Zip code
School _____ Grade _____
Mother's Name _____ Cell _____
Mother's Employer _____ Work Ph. _____
Father's Name _____ Cell _____
Father's Employer _____ Work Ph. _____
Who has legal custody of the patient? _____

Ins. Subscriber _____ SS#_____ DOB_____
Dental Ins. Co. _____ Policy # _____
Emergency Contact Person _____ Ph. _____
Whom may we thank for referring you to us? _____

Names and ages of other children in the family _____

_____

## Consent for Dental Treatment

I request and authorize the Dentist to examine and clean my child's teeth. I request and authorize the taking of dental x-rays as may be considered necessary by the Dentist and her associates to diagnose any possible dental problems. I will allow photographs to be taken of my child or child's teeth for diagnostic purposes. I understand that any dental procedure for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The Denitist and associates will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I hereby confirm that all the information on this form is true and I understand that I will be responsible for any charges incurred on this child for dental treatment.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
DDS Signature Date

**NAME** _____ **#** _____ **PATIENT ACCOUNT REGISTRATION**

Patient's Name_____DOB_____

## Dental History

Yes/No Is this your child's 1st trip to the dentist? If no, what was done at the last appt?

_____

Yes/No Has your child experienced any unfavorable reaction from previous dental care?
Please Explain: _____

Yes/No Does either parent have a history of dental decay?

Yes/No Does your child have siblings with dental decay?

Yes/No Has your child ever injured his/her teeth or gums?

Yes/No Does your child have difficulty with speech or movement of tongue?

Yes/No Does your child wear a mouth guard for sports?

Yes/No Does your child now or have they ever sucked fingers, thumb or pacifier?

Yes/No Does your child clench or grind his/her teeth? When? _____

Yes /No Are your child's teeth flossed? If so, by whom?_____

Who brushes your child's teeth (circle) Child Child/Parent Parent
When are their teeth brushed? _____

What is your main concern regarding your child's dental health? _____

**Is your child having problems with any of the following?**

| | | |
|---|---|---|
| Y/N Cavities | Y/N Toothache | Y/N Sensitive Teeth |
| Y/N Trauma | Y/N Gum Infections | Y/N Color of Teeth |
| Y/N Crowding of Teeth | Y/N Abscesses | Y/N Any other Concerns |

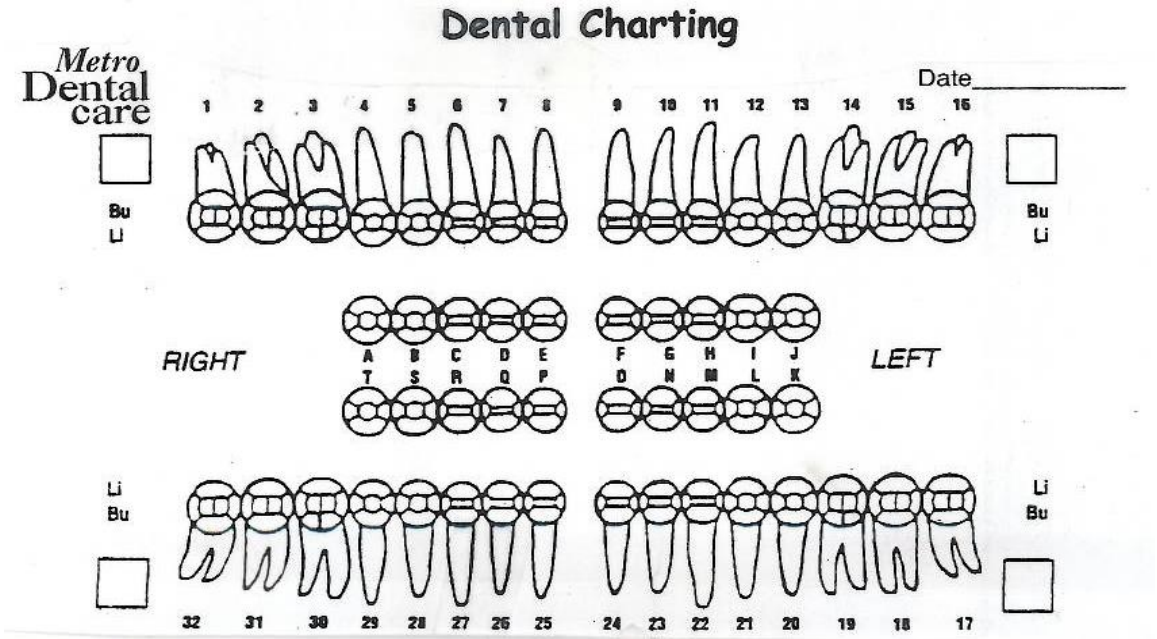
## Fluoride History

Yes/No Is your home water supply fluoridated?

Yes/No Does your child use fluoride toothpaste?

Yes/No Do you give your child any other form of fluoride? What Type?_____

Yes/No Does your child participate in a school fluoride rinse program?




**DENTAL HISTORY** **NAME** _____ **#** _____

Patient's Name_____DOB_____

# Health History

Name of child's Physician _____ Date of last physical exam _____

Yes/No Did the birth mother of child have any problems during pregnancy or birth?
If yes please explain: _____
Yes/No Did the birth mother take any medications during the pregnancy?
If yes please list: _____
Yes/No Has your child ever had a health problem? _____
Yes/No Has your child ever been hospitalized? Please give reasons and dates _____
Yes/No Is your child allergic to anything? _____
Yes/No Is your child currently taking any medications? Please give medication and reason:_____
_____

**Is your child being treated or has your child been treated for any of the following:**

| | | | |
|---|---|---|---|
| Y/N Heart Murmur | Y/N Heart disease | Y/N Abnormal Bleeding | Y/N Asthma |
| Y/N Liver/GI disease | Y/N Anemia/Leukemia | Y/N Diabetes | Y/N AIDS/HIV |
| Y/N Kidney disease | Y/N Rheumatic fever | Y/N Hepatitis | Y/N Mental delays |
| Y/N Speech/hearing | Y/N Epilepsy/Seizures | Y/N Cleft lip/palate | Y/N Physical delays |
| Y/N Cerebral palsy | Y/N Congenital birth defects | Y/N ADD/ADHD | Y/N Downs Syndrome |
| Y/N Cancer/tumors | Y/N Recurrent headaches | Y/N Fetal Alcohol (FAS) | Y/N Infections |

Any health conditions not listed above _____

**Y/N Has your child been advised to be pre-medicated with antibiotics prior to dental treatment?**

Do you consider your child to be: (please circle)
Advanced in the learning process
Progressing normally
Slow in the learning process

Was your child: (please circle) breast fed bottle fed -At what age was it stopped? _____

Does/Did your child sleep with a bottle or sippy cup? Yes No

What was/is fed from the bottle? (Please circle) formula milk juice water other _____

Juice/Chocolate Milk/Soda intake? (Please circle) high moderate low none

Does your child eat sticky treats (such as fruit snacks, fruit roll ups, skittles)? _____
If so, how many times a day/week? _____

Comments: _____

_____

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
DDS Signature Date

**MEDICAL HEALTH HISTORY** **NAME** _____ **#** _____