# Acquaintance Forms

***In this section are confidential forms that are very important. Before your child's first visit, please take the necessary time to accurately fill them out.***

***We suggest that this be done when you are not rushed and can candidly reveal any concerns regarding your child's dental care. The more we know about you and your child, the better we'll be able to serve you.***

***Please bring this completed form with you to your first appointment.***

DEVELOPING POSITIVE ATTITUDES FOR HEALTHY SMILES


The Center for PEDIATRIC
Dental Care & Orthodontics

209 Harvard Street, 2nd Floor • Brookline, Massachusetts 02446

T: (617) 731-KIDS (5437)

www.PediatricDentalCare.com

# Patient Information

Child's Name _____ Nickname _____
FIRST MIDDLE LAST

Sex: ☐ MALE ☐ FEMALE Birthday _____ Age _____ School _____ Grade _____

Name and age of siblings _____

Is this an emergency visit? ☐ YES ☐ NO

Is this your child's first dental visit? ☐ YES ☐ NO

If no, name of former dentist _____ Date of most recent X-rays, if applicable _____

Date and purpose of last visit _____

If Doctor recommends, may we have your permission to take dental X-rays today? ☐ YES ☐ NO

Have any other children in your family been a patient in this office before? ☐ YES ☐ NO

Present dental problems as you see it (if any) _____

Do you have any issues or concerns regarding your child's dental health that you would like addressed?

_____

Has your child had any negative dental experiences? _____

If yes, please explain _____

_____

Name of family dentist _____

Whom may we thank for referring you to the office? _____

# Medical Information

Child's Pediatrician _____

Address _____ Phone _____

Date of last physical _____

| | YES | NO |
|---|---|---|
| Is your child in good health? | ☐ | ☐ |
| Are your child's immunizations up to date? | ☐ | ☐ |
| Is your child being treated for any condition presently? | ☐ | ☐ |
| If so, please explain _____ | | |
| Is your child taking any medications or drugs? | ☐ | ☐ |
| If so, please explain _____ | | |
| Has your child ever been hospitalized or had surgery? | ☐ | ☐ |
| If so, please explain _____ | | |
| Does your child have any allergies or reactions to any medications? | ☐ | ☐ |
| If so, please explain _____ | | |

Does your child have any allergies to the following?

☐ Pollen ☐ Food ☐ Food Dyes ☐ Latex ☐ Dust ☐ Other _____

Has your child had any history or difficulty with any of the following conditions? Please check YES or NO:

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Allergies to Medications / Food / Other | ☐ | ☐ | Chronic Ear Infections | ☐ | ☐ | Immune Disorders (AIDS, ARC, HIV) |
| ☐ | ☐ | Anemia or Blood Disorder | ☐ | ☐ | Cleft Lip/Palate | ☐ | ☐ | Intellectual & Developmental Disability |
| ☐ | ☐ | Asthma | ☐ | ☐ | Convulsions/Seizures | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Attention Deficit Disorder | ☐ | ☐ | Diabetes | ☐ | ☐ | Leukemia |
| ☐ | ☐ | Autism Spectrum | ☐ | ☐ | Down Syndrome | ☐ | ☐ | Neurological Problems |
| ☐ | ☐ | Behavioral Disorder | ☐ | ☐ | Emotional Disturbance | ☐ | ☐ | Nutritional Deficiency |
| ☐ | ☐ | Bladder Conditions | ☐ | ☐ | Epilepsy | ☐ | ☐ | Oral Ulcers |
| ☐ | ☐ | Blood Transfusions | ☐ | ☐ | Excessive Bleeding Problem | ☐ | ☐ | Orthopedic Problems |
| ☐ | ☐ | Birth Defects | ☐ | ☐ | Excessive Gagging | ☐ | ☐ | Premature Birth |
| ☐ | ☐ | Bone or Joint Problems | ☐ | ☐ | Fainting or Dizziness | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Brain Injury | ☐ | ☐ | Growth & Development Problems | ☐ | ☐ | Scoliosis |
| ☐ | ☐ | Bruising Easily | ☐ | ☐ | Hearing/Speech Problems | ☐ | ☐ | Sickle Cell Anemia |
| ☐ | ☐ | Cancer or Malignancies | ☐ | ☐ | Heart Disease | ☐ | ☐ | Spina Bifida |
| ☐ | ☐ | Cerebral Disorder | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Syndrome _____ |
| ☐ | ☐ | Child Abuse | ☐ | ☐ | Hemophilia | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Chronic Adenoid/Tonsil Infection | ☐ | ☐ | Hepatitis or Liver Disease | ☐ | ☐ | Visual Impairment |
| ☐ | ☐ | Chronic Headaches | ☐ | ☐ | Hyperactivity | ☐ | ☐ | Other_____ |

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information that has not been covered. _____

_____

# Dental Information

| | YES | NO |
|---|---|---|
| Was your child bottle fed? | ☐ | ☐ |
| If yes, until what age?_____ | | |
| Was your child breast fed? | ☐ | ☐ |
| If yes, until what age?_____ | | |
| Has your child ever had any injuries to his/her teeth, mouth, head, or jaws? | ☐ | ☐ |
| If yes, describe _____ | | |
| Does your child brush daily? | ☐ | ☐ |
| Does an adult assist with the brushing? | ☐ | ☐ |
| flossing? | ☐ | ☐ |

Does your child have any of the following mouth habits?

☐ Finger Sucking ☐ Thumb Sucking ☐ Pacifier ☐ Tongue Thrusting ☐ Lip Sucking

☐ Mouth Breather ☐ Teeth Grinding ☐ Other

Does your child receive fluoride in any of the following forms?

☐ In Vitamins ☐ In Water Supply ☐ In Toothpaste ☐ In Rinse/Gel ☐ In Tablets/Drop Dosage: ____Mg/Day

Please check any of the following that may describe your child:

☐ Outgoing ☐ Cooperative ☐ High Strung ☐ Shy ☐ Anxious ☐ Moody ☐ Stubborn

☐ Trusting ☐ Friendly ☐ Defiant

How do you expect your child to react to his/her visit today? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

How may we help you to make this a positive experience for your child?

_____

# General Information

Parent's Full Name _____ ❑ MALE ❑ FEMALE Birthdate _____

Address _____ Zip _____ Phone _____

Occupation _____ Employed by _____

Business Phone _____ Cell Phone _____

Parent's Full Name _____ ❑ MALE ❑ FEMALE Birthdate _____

Address (if different) _____ Zip _____ Phone _____

Occupation _____ Employed by _____

Business Phone _____ Cell Phone _____

E-mail Address _____ Preferred Contact Number H☐ C☐ W☐

**Marital Status:** ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Other

**Child lives with:** ❑ Both Parents ❑ Mother ❑ Father ❑ Other

**Dental Insurance Information** **Please note that we file insurance for the Primary Carrier only**

Subscriber's Name _____ Employer's Name _____

Subscriber ID # _____ Group # _____

Insurance Carrier _____ Carrier's Phone # _____

Carrier's Address _____

*I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and 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 need.*

_____ _____ _____

*Signature of parent or guardian* *Relationship* *Date*

***Admin + Clinical***

***OFFICE USE***

***MED HX REV BY ADMIN:*** _____ ***CLINICAL:*** _____