New Patient Questionnaire

Child's Name________________________________ Nickname____________________
Birth Date______________ Age_______ Sex_______ Weight____________________
Child's Physician ____________________________Physician's Ph #_______________

Dental History

Has your child been to the dentist before? Yes No
If yes, does your child go regularly? Yes No Last visit ____________
Were x-rays taken? Yes No Date________________
Dentist's name _________________
Address________________________
____
Phone__________________________
Comments____
Has your child ever had a toothache? Yes No
Is your child nervous about this visit? Yes No
Is there fluoride in your drinking water? Yes No
Does your child take a fluoride supplement? Yes No
If yes, what: ________ Who prescribed: ________________When: ___________
Does your child brush his/her own teeth? Yes No
Do you help your child brush? Yes No
Does your child use dental floss? Yes No
Has your child injured their teeth? Yes No
If yes, explain: ____
Is there a history of tooth decay in the family? Yes No
If yes, explain: ____
Does (or did) your child have any of the following habits? (please check)
___Clenching or grinding teeth ___Finger or thumb habit
___Mouth breathing ___Pacifier

Diet History

How many meals does your child eat per day? _________
How many snacks does your child eat per day? _________
List three of your child's favorite snacks ________________________________
Was your child breast fed? Yes No
Age started:____________ Age stopped:____________
Was your child bottle fed? Yes No
Age started:____________ Age stopped:____________
If bottle fed, the bottle usually contained: ______________________________________
Was your child allowed to fall asleep with bottle? Yes No
Were teeth cleaned after naptime/nighttime feedings? Yes No

Medical History

Is your child in good health? Yes No
Is your child taking any medication? (list below) Yes No
Is your child sensitive/allergic to any medication? (list below) Yes No
Is your child sensitive/allergic to any foods?(list below) Yes No
Is your child sensitive/allergic to Latex? Yes No
Does your child bruise easily? Yes No

Does your child bleed excessively when cut? Yes No
Was your child ever hospitalized or had surgery? Yes No
If yes, when:______________ Why:___________________________________
Ever been treated at the hospital emergency room? Yes No
Does your child have (or had) any of the following conditions:
If yes, state when diagnosed.

Cancer	Yes	No
ADD/ADHD	Yes	No
Developmental disability	Yes	No
Cerebral Palsy	Yes	No
Seizures	Yes	No
Anemia	Yes	No
Rheumatic fever	Yes	No
Allergies	Yes	No
Asthma (or Reactive Airway Disease)	Yes	No
Diabetes	Yes	No
Digestive disorders	Yes	No
Heart disease or defects	Yes	No
Heart murmur	Yes	No
Liver disease	Yes	No
Kidney disease	Yes	No
Tuberculosis (or exposure)	Yes	No
Hepatitis A, B or C	Yes	No
AIDS/HIV positive	Yes	No
Auto Immune disorder	Yes	No
Blood disorder	Yes	No
Hearing difficulty	Yes	No
Speech problems	Yes	No
Frequent colds	Yes	No
Frequent ear infections	Yes	No
Pregnant	Yes	No

Any other condition not listed above: ____

List current medications: ____
Why: ____
List medications allergic/sensitive to: ____
List food allergic/sensitive to: ____

Additional Comments or Remarks: ____
____

The signature of the parent/guardian below authorizes Dr. Krista V. Badger to perform a dental exam and cleaning (if necessary) on the above named child and to obtain x-rays.

____________________________ ______________________ ____________________
Signature Relation to patient Date