PEDIATRIC DENTISTRY
Drs. Spangler, Lambert & Lipp

Demographic Information

Child's Legal Name: _____ Preferred Name: _____
Date of Birth: _____ Gender: _____
Address: _____

Legal Guardian (1)
Full Name: _____ Relationship to Child: _____
Date of Birth: _____ Cell Phone: _____
Social Security #: _____ Work Phone: _____
Employer: _____ Email: _____
Address (if different from child): _____

Legal Guardian (2)
Full Name: _____ Relationship to Child: _____
Date of Birth: _____ Cell Phone: _____
Social Security #: _____ Work Phone: _____
Employer: _____ Email: _____
Address (if different from child): _____

Emergency Contact
Full Name: _____ Relationship to Child: _____
Phone: _____

Dental Insurance Information

Primary Dental Insurance: _____ Policy Holder: _____
Policy Number: _____ Group Number: _____

Secondary Dental Insurance: _____ Policy Holder: _____
Policy Number: _____ Group Number: _____

Medical History Information

Primary Physician: _____ Phone Number: _____

Is your child being treated by a physician at this time? ☐ YES ☐ NO
Reason _____
Does your child have any diagnosed medical conditions? ☐ YES ☐ NO
List condition(s) _____
Is your child taking any medications, vitamins, or dietary supplements? ☐ YES ☐ NO
List name(s) and dosage(s): _____
Has your child ever been hospitalized, had surgery, significant injury, or illness? ☐ YES ☐ NO
Describe: _____
Does your child have any allergies (ex: antibiotics, latex, anesthetics, metals, or dyes)? ☐ YES ☐ NO
List and describe reaction: _____
Is your child up to date on immunizations against childhood disease? ☐ YES ☐ NO
If no, please list missed or waived vaccinations: _____

*Please mark "**YES**" if your child has a history of the following conditions. For each "YES", provide details at the bottom of the list. Mark "**NO**" after each line if none of these conditions applies to your child.*

Complications at birth, prematurity, inherited conditions, syndromes, or birth defects	☐ YES ☐ NO
Problems with physical growth or development	☐ YES ☐ NO
Sinusitis, chronic adenoid/tonsil infections	☐ YES ☐ NO
Sleep apnea, snoring, or mouth breathing	☐ YES ☐ NO
Congenital heart defect or disease, heart murmur, rheumatic fever or rheumatic disease	☐ YES ☐ NO
Irregular heart beat or high blood pressure	☐ YES ☐ NO
Asthma, reactive airway disease, wheezing, breathing problems, or Cystic Fibrosis	☐ YES ☐ NO
Frequent colds or coughs, bronchitis, or pneumonia	☐ YES ☐ NO
Jaundice, hepatitis, or liver problems	☐ YES ☐ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcers, or intestinal problems	☐ YES ☐ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐ YES ☐ NO
Bladder or kidney problems, bedwetting	☐ YES ☐ NO
Fine or gross motor deficits, joint problems, scoliosis	☐ YES ☐ NO
Rash, hives, eczema, or skin problems	☐ YES ☐ NO
Impaired vision, visual processing, hearing, or speech	☐ YES ☐ NO
Developmental disorders, learning problems, or intellectual disability	☐ YES ☐ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	☐ YES ☐ NO
Autism, autism spectrum disorder, sensory integration disorder	☐ YES ☐ NO
Recurrent headaches, migraines, fainting, or dizziness	☐ YES ☐ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventricularatrial)	☐ YES ☐ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐ YES ☐ NO
Behavioral, emotional, or communication problems/treatment	☐ YES ☐ NO
Diabetes, hyperglycemia, or hypoglycemia	☐ YES ☐ NO
Thyroid, pituitary, or hormonal problems	☐ YES ☐ NO
Anemia, sickle cell disease/trait, or blood disorder	☐ YES ☐ NO
Hemophilia, bruising easily, frequent nosebleeds, or excessive bleeding	☐ YES ☐ NO
Cancer, tumor, or other malignancy	☐ YES ☐ NO
Chemotherapy, radiation therapy, bone marrow transplant, or organ transplant	☐ YES ☐ NO
Human immunodeficiency virus (HIV/AIDS), cytomegalovirus (CMV) or tuberculosis (TB)	☐ YES ☐ NO
Has your child been prescribed a premedication (antibiotic) for dental procedures?	☐ YES ☐ NO

Provide details here: _____

_____

Supplemental questions for an infant or toddler

How many weeks was your child at birth (gestational age)? _____ Birth Weight _____

Was your child breast-fed? ☐ YES ☐ NO

If yes, how long? _____

If yes, were there any issues with latching? ☐ YES ☐ NO

Was your child bottle fed? ☐ YES ☐ NO

If yes, how long? _____

Does your child sleep with a bottle or sippy cup? ☐ YES ☐ NO

Does your child have a bottle of milk or milk substitute immediately before bedtime? ☐ YES ☐ NO

What type of cup does your child currently use?

☐ Bottle ☐ Sippy cup ☐ Straw cup ☐ 360 cup ☐ Open cup

Does or did your child use a pacifier, suck their thumb or fingers? ☐ YES ☐ NO

If yes, please describe_____

Has your child experienced any feeding, swallowing, or speech problems? ☐ YES ☐ NO

If yes, please describe: _____

When did you begin brushing your child's teeth? _____

Additional Information

Is there any other medical history information the dentist should be informed of? ☐ YES ☐ NO

If yes, please describe _____

Dental History

What is your primary concern about your child's oral health? _____

Is there a family history of dental problems (such as cavities or gum disease)? ☐ YES ☐ NO

If yes, please describe: _____

Does your child have a history of any of the following? For each YES please describe:

Inherited dental characteristics	☐ YES ☐ NO	_____
Mouth sores or fever blisters	☐ YES ☐ NO	_____
Bad breath	☐ YES ☐ NO	_____
Bleeding gums	☐ YES ☐ NO	_____
Cavities or decayed teeth	☐ YES ☐ NO	_____
Toothache	☐ YES ☐ NO	_____
Injury to teeth, mouth, or jaws	☐ YES ☐ NO	_____
Clenching/grinding of teeth	☐ YES ☐ NO	_____
Snoring, sleep apnea	☐ YES ☐ NO	_____
Excessive gagging	☐ YES ☐ NO	_____
Mouth breathing	☐ YES ☐ NO	_____
Lisp or tongue thrust	☐ YES ☐ NO	_____

How often does your child brush? _____ Does someone help your child brush? ☐ YES ☐ NO

How often does your child floss? _____ Does someone help your child floss? ☐ YES ☐ NO

What type of toothbrush does your child use? ☐ Manual (regular) ☐ Electric ☐ Autobrush

Does your child use fluoridated toothpaste? ☐ YES ☐ NO

What is the source of your drinking water at home?

☐ City /community supply ☐ Private well ☐ Bottled water

Do you use a water filter at home? ☐ YES ☐ NO

If yes, what is your filtering system? _____

Please check all sources of fluoride your child receives:

☐ City/community water supply ☐ Toothpaste ☐ Mouthwash ☐ Prescription supplement

☐ Fluoride treatment by pediatrician/physician (if selected, date of last treatment: _____)

Is your child on a special/restrictive diet or a picky eater? ☐ YES ☐ NO

If yes, please describe _____

Does your child have a diet that is high in sugars, starches, or processed carbohydrates? ☐ YES ☐ NO

If yes, please describe _____

Does your child drink beverages aside from water and milk (or milk substitute)? ☐ YES ☐ NO

If yes, please list _____

Has your child ever had a difficult dental appointment? ☐ YES ☐ NO

If yes, please describe _____

Is there anything else we should know before treating your child? ☐ YES ☐ NO

If yes, please describe _____

_____ _____

(Signature or patient or legal guardian) (Date)