Smiles 4 Kids Pediatric Dentistry, Cindy Pong DDS

11350 Springfield Pike I Cincinnati, OH 45246
P: 513-771-5231 I F: 513-771-5109

Date: _____

Patient Name: DOB:

DENTAL HISTORY

Is this your child's first dental visit? **YES / NO**
If no, date of last dental care visit: _____
Were and x-rays taken when your child previously visited the dentist? **YES / NO**
If yes, most recent date taken: _____

Does your child eat between meals: **YES / NO**

When does your child brush his/her teeth?
____Morning ____During the day ____Bedtime

Does your child floss? **YES / NO**

How does your child receive Fluoride?
____Community Water ____Well water ____Tap water ____Fluoride drops/tablets
____Fluoride rinse/gel ____Toothpaste ____Fluoride vitamins/supplements

Have cavities been noted in the past? **YES / NO**
Were any teeth (baby or permanent) removed by extraction? **YES / NO**
Was it suggested that the space be maintained? **YES / NO** Was an appliance placed? **YES / NO**

Have there been any injuries to teeth, such as falls, blows, chips, etc.? **YES / NO**
If yes, when and describe: _____

Has your child had any problem with dental treatment in the past? **YES / NO**
If yes, describe: _____

Has anyone in the family, including parents, had orthodontics? **YES / NO**
Has your child ever received a local anesthetic? **YES / NO**
Has your child ever received sealants? **YES / NO**
Does your child think there is anything wrong with his/her teeth? **YES / NO**
If yes, when and describe: _____

How do you think your child will behave during today's visit?
____Good ____Average ____Poor ____Unsure

MEDICAL HISTORY

Name of Physician, family/pediatrician: _____ Phone: _____

Does your child have any health problems? **YES / NO** If yes, explain:

_____

Is your child under the care of a physician? **YES / NO**

If yes, since when and why? _____

Has your child had any serious illness? **YES / NO**

If yes, when and what? _____

Is your child up to date on their vaccinations? **YES / NO**

If no, please explain: _____

Please list any medications your child is currently taking:

_____ _____

_____ _____

Does the patient have any allergies? (Check which ones if yes): **YES / NO**

____Latex ____Seasonal Allergies ____Food ____Penicillin/Amoxicillin

____Sulfa ____Codeine ____Other: _____

Does your child have a heart murmur? **YES / NO**

If yes, does your child require antibiotic premedication for dental visits? **YES / NO**

Does your child see a cardiologist? **YES / NO** Doctor's name? _____

Is surgery contemplated? **YES / NO**

If yes, what and when? _____

Does your child experience severe or prolonged bleeding? **YES / NO**

Does your child have AIDS or has he/she tested HIV positive? **YES / NO**

Has your child tested positive for hepatitis? **YES / NO**

Is your child subject to any of the following nervous disorders? **YES / NO** If yes, which ones?

____Fainting ____ Seizures ____Dizziness ____Behavioral/Learning problems

Check any of the following that may pertain to your child?

____ ADD/ADHD ____ Developmental Delay ____Infections ____Asthma

____ Diabetes ____Kidney/Bladder Problems ____Autism Spectrum Disorder ____Epilepsy/Seizures

____Liver Problems ____Cancer/Tumor ____Eyesight Problems ____Sensory Integration Disorder

____Cerebral Palsy ____Hearing Loss ____Speech Impairments ____Congenital Birth Defects

____Heart Disease ____Other: _____

CONSENT

I CERTIFY THAT THE PRECEDING INFORMATION IS COMPLETE AND ACCURATE

_____ _____

Parent/Guardian Signature Date