



# CORNERSTONE CHILDREN'S DENTISTRY, P.A.

## I. SOCIAL HISTORY

Patient's Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Patient's Address \_\_\_\_\_ Home Phone \_\_\_\_\_

School \_\_\_\_\_ Child's Social Security # \_\_\_\_\_

Name and type of child's pet \_\_\_\_\_ Favorite interest / hobby \_\_\_\_\_

How do you expect your child to react to his/her visit today?  Excellent  Good  Fair  Poor  Not sure

Child lives with:  Both parents  Mother  Stepmother  Father  Stepfather  Grandparent  Other \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Address \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Mother's Full Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Address \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Emergency Contact Name (if parent unavailable) \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

Other children in the family (Names and ages) \_\_\_\_\_

How did you hear about our office?  Doctor \_\_\_\_\_  Patient \_\_\_\_\_  Other \_\_\_\_\_

Reason for bringing child to the dentist \_\_\_\_\_ E-mail \_\_\_\_\_

## II. MEDICAL HISTORY

Child's Physician \_\_\_\_\_ Year of last physical exam \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Yes  No Were there any problems during pregnancy or birth of your child? \_\_\_\_\_

Yes  No Are your child's immunizations up to date? If not, why? \_\_\_\_\_

Yes  No Is your child allergic to any medicines or foods? If yes, what? \_\_\_\_\_

Yes  No Is your child taking any medicines? If yes, what? \_\_\_\_\_

Yes  No Has your child been hospitalized? If yes, explain. \_\_\_\_\_

Yes  No Has your child had any surgeries? If yes, explain. \_\_\_\_\_

Yes  No Has your child received medical treatment within the last 6 months? If yes, explain. \_\_\_\_\_

Yes  No Does your child have any hearing, sight, speech, or learning problems? If yes, explain. \_\_\_\_\_

Please check any that pertain to your child (past or present):

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Heart Condition / Heart Murmur | <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Seizure Disorder            | <input type="checkbox"/> ADHD              | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> Liver Problems              | <input type="checkbox"/> Kidney Problems   | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Sickle Cell Anemia             | <input type="checkbox"/> Mental / Emotional Disorder | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Nervous System Disorder        | <input type="checkbox"/> HIV / AIDS                  | <input type="checkbox"/> Other _____       |   |

## III. DENTAL HISTORY

Yes  No Is this your child's first dental visit? If no, name of previous dentist \_\_\_\_\_

Yes  No Are there any hereditary dental problems in the family (missing, extra teeth, etc.)? \_\_\_\_\_

Yes  No Has your child or any family member experienced any unfavorable reaction to dental treatment? \_\_\_\_\_

Yes  No Has your child suffered injuries to the head, mouth, or teeth? Explain \_\_\_\_\_

Yes  No Does your child have a thumb, finger, or pacifier habit? \_\_\_\_\_

Yes  No Does your child take fluoride supplements? Is drinking water:  Public / City Water  Private Well  Bottled Water

I attest that the above information is true to the best of my knowledge. I also consent to the performance of a diagnostic exam, radiographs, dental cleaning, and fluoride treatment upon my child as deemed necessary and appropriate by the dentist.

Signature of Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_