CIPES PEDIATRIC DENTISTRY

798 Farmington Avenue, West Hartford, CT 06119

PATIENT REGISTRATION

Patient Name: _____
LAST FIRST MIDDLE PREFERRED NAME

Address _____
STREET APT.# CITY STATE ZIP CODE

Phone_____ Date of Birth _____ Age_____ Sex_____

School _____ Grade _____

Father's Name: Mr. Dr. _____
LAST FIRST MIDDLE EMPLOYER WORK PHONE#

Home Address _____
STREET CITY STATE ZIP CODE HOME PHONE#

S.S.No. Father_____ Date of Birth (Father)_____ Cell Phone # (Father)_____

E-mail Address _____

Mother's Name: Ms. Dr. _____
LAST FIRST MIDDLE EMPLOYER WORK PHONE#

Home Address _____
STREET CITY STATE ZIP CODE HOME PHONE#

S.S.No. Mother_____ Date of Birth (Mother)_____ Cell Phone # (Mother) _____

E-mail Address _____

Because your child is a minor your permission is needed to treat your child. If you do not plan to accompany your child to an appointment please advise us in advance so that we can be sure you understand what is to be done that day.

Name of friend or neighbor who can reach you in case of emergency: _____

Address _____
STREET CITY STATE ZIP CODE PHONE#

Primary Dental insurance carrier: _____
NAME OF INSURANCE COMPANY SUBSCRIBER NAME POLICY OR ID#

Secondary Dental insurance carrier: _____
NAME OF INSURANCE COMPANY SUBSCRIBER NAME POLICY OR ID#

Husky? ☐ YES ☐ NO

How you happened to call this office or the name of the person who referred you here _____

_____

Authorization to pay benefits: I hereby authorize payment directly to the above named dentist of the dental benefits otherwise payable to me for services rendered.

Authorization to release information: I hereby authorize the above named dentist to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

Financial responsibility: I will be responsible for any professional fees incurred for dental services for my child. I agree to pay reasonable collection costs and attorney's fees in the event my account is turned over for collection. I understand that account balances outstanding more than 60 days from treatment date will bear interest at .66% per month or 8% a year.

_____ _____
Signature of parent/guardian Date

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PEDIATRIC MEDICAL HISTORY

Patient Name:_____ **D.O.B.:** _____

Name/address/phone of primary physician:_____

Name/address/phone of medical specialists:_____

Weight: _____ **Date of last physical examination:** _____

Is your child being treated by a physician at this time? Reason _____	☐ YES	☐ NO
Is your child taking any medication (prescription or over the count), vitamins, or dietary supplements?	☐ YES	☐ NO
List name, dose, frequency & date started: _____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?	☐ YES	☐ NO
List date & describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe _____	☐ YES	☐ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____	☐ YES	☐ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	☐ YES	☐ NO
Is your child up to date on immunizations against childhood diseases?	☐ YES	☐ NO

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

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions	☐ YES	☐ NO
Problems with physical growth or development	☐ YES	☐ NO
Sinusitis, chronic adenoid/tonsil infections	☐ YES	☐ NO
Sleep apnea/snoring, mouth breathing, or excessive gagging	☐ YES	☐ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	☐ YES	☐ NO
Irregular heart beat or high blood pressure	☐ YES	☐ NO
Asthma, reactive airway disease, wheezing, or breathing problems	☐ YES	☐ NO
Cystic fibrosis	☐ YES	☐ NO
Frequent colds or coughs, or pneumonia	☐ YES	☐ NO
Frequent exposure to tobacco smoke	☐ YES	☐ NO
Jaundice, hepatitis, or liver problems	☐ YES	☐ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	☐ YES	☐ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐ YES	☐ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	☐ YES	☐ NO
Bladder or kidney problems	☐ YES	☐ NO
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	☐ YES	☐ NO
Rash/hives, eczema or skin problems	☐ YES	☐ NO
Impaired vision, hearing, or speech	☐ YES	☐ NO
Developmental disorders, learning problems/delays, or intellectual disability	☐ YES	☐ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures	☐ YES	☐ NO
Autism/autism spectrum disorder	☐ YES	☐ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	☐ YES	☐ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	☐ YES	☐ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐ YES	☐ NO
Behavioral, emotional, communication, or psychiatric problems/treatment	☐ YES	☐ NO
Abuse (physical, psychological, emotional, or sexual) or neglect	☐ YES	☐ NO
Diabetes, hyperglycemia, or hypoglycemia	☐ YES	☐ NO
Precocious puberty or hormonal problems	☐ YES	☐ NO
Thyroid or pituitary problems	☐ YES	☐ NO
Anemia, sickle cell disease/trait, or blood disorder	☐ YES	☐ NO
Hemophilia, bruising easily, or excessive bleeding	☐ YES	☐ NO
Transfusions or receiving blood products	☐ YES	☐ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	☐ YES	☐ NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS	☐ YES	☐ NO

PROVIDE DETAILS HERE: _____

_____

_____

_____

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PEDIATRIC MEDICAL HISTORY

Patient Name:_____ **D.O.B.:** _____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ☐ YES ☐ NO

If YES, describe _____

_____

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

How would you describe:

Your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

The oral health of your other children? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ N/A

Is there a family history of cavities? ☐ YES ☐ NO If YES, indicate all that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister

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

Inherited dental characteristics ☐ YES ☐ NO _____

Mouth sores or fever blisters ☐ YES ☐ NO _____

Bad breath ☐ YES ☐ NO _____

Bleeding gums ☐ YES ☐ NO _____

Cavities/decayed teeth ☐ YES ☐ NO _____

Toothache ☐ YES ☐ NO _____

Injury to teeth, mouth or jaws ☐ YES ☐ NO _____

Clinching/grinding his/her teeth ☐ YES ☐ NO _____

Jaw joint problems (popping, etc) ☐ YES ☐ NO _____

Excessive gagging ☐ YES ☐ NO _____

Sucking habit after one year of age ☐ YES ☐ NO If YES, which: ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ☐ YES ☐ NO

How often does your child floss his/her teeth? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss? ☐ YES ☐ NO

What type of toothbrush does your child use? ☐ Hard ☐ Medium ☐ Soft ☐ Unsure

What toothpaste does your child use? _____

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, type of filtering system: _____

Please check all sources of fluoride your child receives:

☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamin

☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other: _____

Does your child regularly eat 3 meals each day? ☐ YES ☐ NO

Is your child on a special or restricted diet? ☐ YES ☐ NO If YES, describe: _____

Is your child a "picky" eater? ☐ YES ☐ NO If YES, describe: _____

Does your child have a diet high in sugars or starches? ☐ YES ☐ NO If YES, describe: _____

Do you have any concerns regarding your child's weight? ☐ YES ☐ NO If YES, describe: _____

How frequently does your child have the following?

Candy or other sweets ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Product _____

Chewing gum ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Type _____

Snacks between meals ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Usual Snack _____

Soft drinks* ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Product _____

(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? ☐ YES ☐ NO If YES, list: _____

Does your child wear a mouth guard during these activities? ☐ YES ☐ NO If YES, type: _____

Has your child been examined or treated by another dentist? ☐ YES ☐ NO

If YES, Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ☐ YES ☐ NO Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ YES ☐ NO If, YES, when? _____

Has your child ever had a difficult dental appointment? ☐ YES ☐ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

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

If YES, describe: _____

_____

_____ _____ _____ _____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing history