TERRIFIC TEETH
PEDIATRIC DENTISTRY

1229 Silver Lane, Suite 2
McKees Rocks, PA 15136
Tel: (412) 859-3199
Email: info@terrificteethpd.com

Today's Date: _____
Child's Name: _____ Nickname: _____ Gender: _____ Weight: _____
Date of Birth: _____
Home Address: _____

Home Phone #: _____
Referred by / how did you hear of us? _____

Child's Doctor: _____

Account Responsibility: _____
Date of Birth: _____
Dental Insurance / Self Pay: _____
Employer: _____
SSN: _____

Name of person completing form: _____ Relationship to Child: _____
In case of Emergency, please notify: _____ Phone: _____

---------- // Parent / Guardian 1 // ----------

First Name: _____ Last Name: _____ Mobile: _____
Employer: _____ Occupation: _____ Email: _____

---------- // Parent / Guardian 2 // ----------

First Name: _____ Last Name: _____ Mobile: _____
Employer: _____ Occupation: _____ Email: _____

MEDICAL and DENTAL History

1. Is your child having dental problems? Y / N If YES, please explain: _____
2. Is this his/her first visit to any dentist? Y / N If not, date of last visit: _____
3. Names and ages of brothers and sisters: _____
4. Place of birth: _____ Was water fluoridated? _____ Is it now? _____
5. Any problems or medications during pregnancy? _____
6. Is your child in good health now? _____ Taking any medication? _____
7. Has your child had any of the following?

Heart disease/defects		Anemia/Blood Disorders		Frequent Headaches	
Diabetes		Hepatitis/Liver Disease		Cleft Palate or Lip	
Convulsions		Bleeding Difficulties		Cerebral Palsy	
Kidney Disease		Birth Defects		Sight Problems	
Dizziness or Fainting		Hearing Problems		Any Other Illness	
Rheumatic Fever		Nervous Condition		Delay in Phyical or Mental Development:	
Breathing Difficulties		Emotional Problems			
Blood Transfusions		Other Conditions			

8. Is your child allergic to any food or drugs? (Penicillin, Novocaine, other local anestetics, aspirin, etc.) _____
9. Has your child ever been warned by a physician against taking any specific drug medications? _____
10. Has your child ever been hospitalized for any reason? _____ When? _____
    For what reason? _____
11. Age at which first tooth erupted: _____ Did your child ever sleep with a bottle?
    What did the bottle contain? _____
12. Does your child brush his/her teeth? _____
13. Does your child have any speech difficulties? _____
14. What habits does your child have which might affect the teeth or mouth?
    Mouth breather _____ Grinding _____ Clenching _____ Sucks thumb/finger _____ Other _____
15. Has your child had any dental injuries? _____ Explain: _____
16. Has your child had any fluoride treatments? _____ Date of last treatment _____
17. Has your child ever had fluoride medication at home? _____ Type: _____
18. Diet Summary (frequency and types of sweets): _____
19. General dental history of other family members: _____
20. Any other information you feel we should know about your child: _____