Creekwood Dental Arts

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Chart#: ____________

FOR OFFICE USE ONLY

Patient Name: ____________ * ____________ * ____ ____________

Last First MI Preferred Name

Title: ____________ Mr/Ms/Mrs/etc

Gender:* ◯ Male ◯ Female

Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* ____________ **Prev. Visit:** ____________ **Email Address:** ____________

Phone: ____________ * ____________ ____________ ____________

Home Mobile Work Ext

Best time to call: ____________

Address: ____________ * ____________

Address 1 Address 2

____________ * ____________ * _____-____ *

City State Zip Code

Who is the legal guardian? Please enter name and relationship below:

Legal Guardian: *

Legal Guardian's Date of Birth (DOB): * ____________

Legal Guardian's Social Security Number (SSN): * ____________

Legal Guardian's Address: *

What is your most important concern today?

Are you currently taking any medications (including prescription, OTC medications, vitamins, and supplements)? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Medications:

Does your child have a history of antibiotic therapy for recurring infection(s)? * ◯ Yes ◯ No

Do you have any allergies and/or allergies to medications? If yes, please list all allergies below: * ◯ Yes ◯ No

Allergies:

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Have you ever had surgery? If yes, please list all surgeries. * ◯ Yes ◯ No

Surgeries:

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Have you ever been hospitalized? If yes, please list all hospitalizations. * ◯ Yes ◯ No

Hospitalizations:

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Name of physician, approximate date of last physical exam, and physician's phone number: *

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Medical Care (Select all that apply): *

- ☐ Special healthcare needs
- ☐ Active medical conditions or disabilities
- ☐ History of complications during pregnancy or infancy
- ☐ Avoid any recommended preventative services (including vaccinations)
- ☐ Have health goals you are trying to help him/her achieve
- ☐ Wish your child was better cared for or that you were more trusting of your child's medical team
- ☐ None

If any responses need further clarification, please describe below:

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Caries/Tooth Decay (Select all that apply): *

- ☐ Have biological parents with a history of adult decay
- ☐ Snack more than twice a day between meals
- ☐ Snack or drink anything other than water within an hour of bedtime
- ☐ Sleep with a bottle
- ☐ Consume sugary drinks (including juice, soda, and/or sports drinks)
- ☐ Consume sugary foods (including crackers, breakfast cereals, chewy fruit snacks, or candy)
- ☐ Have a history of tooth decay or an abscessed tooth
- ☐ None

If any responses need further clarification, please describe below:

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Allergies and/or Food Sensitivities (Select all that apply): *

- ☐ Have identified food sensitivities such as dairy, wheat, soy, or nuts (list below)
- ☐ Eat foods that cause him/her to feel sluggish, hyperactive, or sick
- ☐ Suffer from GI disturbances such as discomfort, bloating, constipation, or diarrhea
- ☐ Have acid reflux or regurgitation
- ☐ Have red, patchy, or itchy skin or ears
- ☐ Get congested frequently
- ☐ Exhibit an unhealthy weight (overweight or underweight)
- ☐ None

If any responses need further clarification, please describe below:

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Exercise and Llifestyle: (Select all that apply): *

- ☐ Get less-than-daily recommended physical exercise
- ☐ Regularly consume processed foods or fast foods
- ☐ Have concentration problems when not stimulated by electronics
- ☐ Have more "screen time" than physical play time
- ☐ Lack interest in exercise or athletics
- ☐ None

If any responses need further clarification, please describe below:

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Behavior (Select all that apply): *

- ☐ Have difficulties with communications
- ☐ Have a diagnosis on the Autism spectrum
- ☐ Have ongoing behavior challenges at home or in school
- ☐ None

If any responses need further clarification, please describe below:

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Dental History (Select all that apply): *

- ☐ Does your child have a history of fear, anxiety, or avoidance behavoir at a medical/dental appointment?
- ☐ Has your child seen an orthodontist?
- ☐ None

Previous Dentist (include most recent dental visit):

____

____

Most recent dental X-rays (date): ________________________

If any responses need further clarification, please describe below:

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Fluoride: (Select all that apply):
Consume water from: *

- [ ] Tap (city) water
- [ ] Filtered tap water
- [ ] Well (country) water
- [ ] Bottled water
- [ ] Take fluoride supplements
- [ ] Receive professionally applied topical fluoride
- [ ] Use toothpaste with fluoride
- [ ] None

If any responses need further clarification, please describe below:

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If not tap water, do you know the fluoride content of the water they drink? ______________________

Home Care (Select all that apply): *

- [ ] Receive daily adult-assisted tooth brushing
- [ ] Have skills to brush independently
- [ ] Receive daily adult-assisted flossing
- [ ] Have skills to floss independently
- [ ] Have professionally applied sealants
- [ ] None

If any responses need further clarification, please describe below:

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Sleep and Airway (Select all that apply): *

- [ ] Snore or make breathing noises when sleeping
- [ ] Breath with his/her mouth open
- [ ] Grind his/her teeth during sleep
- [ ] Experience any learning difficulties
- [ ] Have any "screen time" just before bed
- [ ] Have any history of strep throat, ear infections, or sinusitis
- [ ] Experience bedwetting
- [ ] Have ADHD history, behavior disturbances, or anxiety attacks
- [ ] Have oral habits such as finger, thumb, or pacifier sucking
- [ ] None

If any responses need further clarification, please describe below:

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Dental and Facial Growth and Development (Select all that apply): *

- [ ] Breathe through his/her mouth rather than nose
- [ ] Have any oral habits such as finger, thumb, or pacifier sucking
- [ ] Have a history of receiving breast milk or formula from a bottle rather than breast
- [ ] Have a history of difficulty with latching
- [ ] Have a tongue-tie or lip-tie
- [ ] Prefer a soft diet over harder-to-chew foods
- [ ] Have any issues with speech or articulation of sounds such as "L" or "S"
- [ ] None

If any responses need further clarification, please describe below:

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Function/Bite/TMJ Dysfunction *

- [ ] Have difficulty with tooth eruption or losing primary teeth
- [ ] Choke or gag on foods not chewed well
- [ ] Have clicking, popping or pain in either jaw joint
- [ ] Have foods that are difficult to chew
- [ ] Have extra, missing, or fused teeth
- [ ] None

If any responses need further clarification, please describe below:

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Aesthetics (Select all that apply): *

- [ ] Are there any cranial, facial, or dental abnormalities that concern you?
- [ ] Are there any tooth size or tooth position discrepancies that concern you?
- [ ] Are there any tooth discolorations that concern you?
- [ ] None

If any responses need further clarification, please describe below:

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Child's age (in months) when first tooth erupted ______________

Has your child experienced teething or eruption problems? * ◯ Yes ◯ No

Are there areas in your home that are not considered child proof? * ◯ Yes ◯ No

Has your child had an oral/facial injury? * ◯ Yes ◯ No

What sugary food or drinks do you consume regularly?

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Family History of Medical Conditions (Please list condition and relationship to family member.):

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Any additional health issues/concerns not already addressed:

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- [ ] ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Name of Parent or Guardian completing this form: *

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Signature ______________________________ **Date** ______________

Response Date: ____________