Westport Pediatric Dentistry
305 Post Road East, Westport, CT 06880
(Tel) 203-226-5500 (Fax) 203-226-5501

Patient Information and Health History Form

In order to ensure that your child receives the best care at our practice, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.

Tell Us About Your Child

Child's Name: _____ Patient goes by: _____
FIRST MIDDLE INITIAL LAST (If applicable)

Sex: M ☐ F ☐ Birth Date: _____ Age: _____

Address: _____
APT/UNIT # CITY/STATE/ZIP

Whom may we thank for referring you? _____

Notify in case of an emergency (other than parents): _____ Phone: _____

Relationship to patient: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian name: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Financially Responsible for patient's account? Y ☐ N ☐

Address (if diff from above): _____

Mobile phone: _____

Work phone: _____

Home phone: _____

Employer: _____

Occupation: _____

SSN: _____ Birth Date: _____

E-mail: _____

Do you have dental insurance coverage for minor/child? Y ☐ N ☐

If yes, fill out the following:

Insurance Company Name: _____

Phone Number: _____

Member ID: _____ Group ID: _____

Parent/Guardian name: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Financially Responsible for patient's account? Y ☐ N ☐

Address (if diff from above): _____

Mobile phone: _____

Work phone: _____

Home phone: _____

Employer: _____

Occupation: _____

SSN: _____ Birth Date: _____

E-mail: _____

Do you have dental insurance coverage for minor/child? Y ☐ N ☐

If yes, fill out the following:

Insurance Company Name: _____

Phone Number: _____

Member ID: _____ Group ID: _____

DENTAL HISTORY

What would you like us to do for your child today? _____

Previous Dentist: _____ Phone: _____

Date of last dental care: _____ Date of last x-ray: _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? Y ☐ N ☐

Has your child experienced mouth or chin injury? Y ☐ N ☐

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y ☐ N ☐

Does your child have speech problems? Y ☐ N ☐

Was your child bottle fed? Y ☐ N ☐

If so, how long? _____

Does your child suck his/her thumb, fingers or pacifier? Y ☐ N ☐

Is fluoride taken in any form? Y ☐ N ☐

If so, what form? _____

Other information about your child's dental health or previous treatment: _____

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MEDICAL HISTORY

Were there any difficulties during the pregnancy, delivery (e.g., prematurity) or first year of your child's life?
If yes, describe?_____ ☐ Yes ☐ No

Medical conditions: Does your child have any history of the following? *(Check all that apply)*

General conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning ADHD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior issues: Type_____
- ☐ Emotional disability:
- ☐ Type_____
- ☐ Learning disability:
- Type_____
- ☐ Psychiatric disorder:
- Type_____

Developmental
- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Developmental Delay
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type _____
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures: Type_____
- ☐ Speech prob: Type _____

Hematological (Blood-related)
- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Hemophilia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood

Infectious
- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Venereal disease:
- Type_____

Other
- ☐ Cancer: Type _____
- ☐ Leukemia: Type _____
- ☐ Fainting/headaches (often)
- ☐ Sleep apnea
- ☐ Sleep problems
- ☐ Snoring
- ☐ Syndrome: Type _____
- ☐ Other: _____

If any boxes checked, please describe further: _____

_____

_____

Medications: Is your child CURRENTLY taking any medications?

Drug:	How much? How often?	Reason:

Steroid Use: Has your child had any steroid treatment in the past six months? ..... ☐Yes ☐ No

Allergies: Has your child had any allergic reactions to:

Medications or drugs? _____

Latex?_____

Foods? _____

Other? _____

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Immunizations: Are your child's immunizations current? ☐ Yes ☐ No

Have you ever been told that your child needs to take antibiotics before dental treatment? ☐ Yes ☐ No

Hospitalizations: Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, when, and where? _____

Reason for hospitalization? _____

Surgeries: Has your child had any surgery (operations)? ☐ Yes ☐ No

Date(s) and age(s)? _____

For what reason(s)? _____

Was general anesthesia used? ☐ Yes ☐ No

Were there any complications? If yes: _____ ☐ Yes ☐ No

Child's Physician/Pediatrician: _____ Tel: _____

Address: _____ City: _____ State: ____ Zip: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Your Name: _____

Signature: _____

Relationship to patient: _____ **Date:** _____

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Consent For Dental Treatment

I am the parent, guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize the doctor and the staff to perform any necessary dental services including but not limited to examinations, cleanings, fluoride treatment, x-rays as necessary to diagnose and/or treat my child's dental problem, any necessary dental treatment for my child's teeth and administration of anesthetics that are deemed advisable by the doctor. If I am not present at the appointment, I agree that the adult accompanying my children to their appointment (e.g., relative, nanny, babysitter, au pair, friend, etc.) will authorize treatment on my behalf. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. The doctor will provide an environment that will help children learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments. I will be responsible for any charges incurred for my child for dental treatment.

Please print name (Parent, Guardian, or Personal Representative): _____

Signature:_____ Date: _____

Relationship to Patient: **_____**