



North Hills  
8620 Duncan Ave.  
Pittsburgh, PA 15237  
412-367-2250

Monroeville  
2790 Mosside Blvd.  
Suite 140  
Monroeville, PA 15146  
412-856-6660

Cranberry  
20440 Rt 19  
Cranberry Twp, PA 16066  
724-772-9688

Beaver  
244 College Ave.  
Beaver, PA 15009  
724-888-2684

Today's Date \_\_\_\_\_ Email Address \_\_\_\_\_

Child's Name \_\_\_\_\_ Gender \_\_\_\_\_ Nickname \_\_\_\_\_ Weight \_\_\_\_\_

Date of Birth \_\_\_\_\_ Referred by \_\_\_\_\_

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_

Child's Physician \_\_\_\_\_

Responsibility for Account _____
Date of Birth _____
Dental Insurance Company/ Self Pay _____
Employer _____
Social Security # _____

Name of Person completing form \_\_\_\_\_ Relationship to Child \_\_\_\_\_

In case of Emergency please notify \_\_\_\_\_ Phone \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

### MEDICAL AND DENTAL HISTORY

1. Is your child having any dental problems? \_\_\_\_\_ Please explain \_\_\_\_\_

2. Is this your child's first visit to any dentist? \_\_\_\_\_ If not, date of last visit \_\_\_\_\_

3. Names & 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 or defects _____ | Anemia or Blood Disorders _____  | Frequent Headaches _____                      |
| Diabetes _____                 | Hepatitis or 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 Physical 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 anesthetics, aspirin, etc.) \_\_\_\_\_

9. Has your child ever been warned by a physician against taking any specific drug medication? \_\_\_\_\_

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? \_\_\_\_\_ At what age did he/she stop? \_\_\_\_\_

Does your child brush his/her own teeth? \_\_\_\_\_ If not, who does it? \_\_\_\_\_

Does your child have any speech difficulties? \_\_\_\_\_

What habits does your child have which might affect the teeth or mouth?  
Mouth breather \_\_\_\_\_ Grinding \_\_\_\_\_ Clenching \_\_\_\_\_ Sucks Thumb \_\_\_\_\_ Sucks Finger \_\_\_\_\_ Other \_\_\_\_\_

Has your child had any dental injuries? Explain \_\_\_\_\_

Has your child had any fluoride treatments? \_\_\_\_\_ Date of last treatment \_\_\_\_\_

Has your child ever had fluoride medication at home? \_\_\_\_\_ Type \_\_\_\_\_

Diet Summary (frequent and types of sweets) \_\_\_\_\_

General Dental history of other family members \_\_\_\_\_

Any other information you feel we should know about your child \_\_\_\_\_