McCandless Pediatric Dentistry

Patient Registration

Please print all information clearly

PATIENT'S NAME Last **First** **Middle**

DATE OF BIRTH **Gender** **Preferred name**
Month Day Year

HOME ADDRESS (Number, Street, Route, Etc.)

CITY **STATE** **ZIP**

HOME PHONE **Cell Phone Number**
( ) - **( ) -**

PLEASE PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18 YEARS OR HAS A LEGAL GUARDIAN

Guardian One: Last Name **First Name** **Occupation** **Cell phone**
( ) -

Guardian Two: Last Name **First Name** **Occupation** **Cell phone**
( ) -

MARITAL STATUS OF PARENTS (check one) ☐ **MARRIED** ☐ **SINGLE** ☐**SEPERATED** ☐ **DIVORCED** ☐ **WIDOWED**

WITH WHOM DOES PATIENT LIVE?

WHOM DO WE CONTACT TO SCHEDULE APPOINTMENTS? **Work Phone** **Home Phone**
( ) - **( ) -**

Email:

WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES?:

Last Name **First Name**

Dental Insurance Company Name and Phone Number:

Member ID Number **Policy/Group Number:**

Policyholder's Name **Relationship to Patient**

Social Security Number **Date of Birth**

Mailing Address (if different from patient)

Home Phone Number **Cell Phone Number**
( ) - **( ) -**

Employer's Name and Address:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

PATIENT NAME:_____

DATE OF BIRTH:_____

MEDICAL HISTORY

DATE:_____

Child's Physician:_____ **Date of last exam:**_____

Physician's Address:_____ **Phone:**_____

Is your child in good health? **Yes** **No**
If no, please explain:_____

Is your child up-to-date on required vaccinations? **Yes** **No**
If no, please explain:_____

Was your child adopted? **Yes** **No**
If yes, what age was the adoption?_____

Was the pregnancy and delivery normal? **Yes** **No**
If no, please explain:_____

Does your child have a health problem? **Yes** **No**
If yes, please explain:_____

Has your child ever been hospitalized or been to the emergency room? **Yes** **No**
If yes, please explain:_____

Has your child ever received general anesthesia? **Yes** **No**
If yes, what procedure, any problems?_____

Is your child currently taking any medications? **Yes** **No**
If yes, please list:_____

Does your child have any ALLERGIES? **Yes** **No**
(Environmental, food, medication)
If yes, please list:_____

Has your child ever been treated by a physician for any of the following (circle all that apply):

ADD or ADHD
AIDS or HIV
Anemia
Asthma/Reactive Airway Disease
Arthritis
Autism Spectrum Disorder
Behavioral/Emotional Problems
Blood Disorders
Bleeding Problems/Bruising
Brain Injury
Cancer (Chemotherapy or Radiation)
Celiac's Disease
Cerebral Palsy
Cleft Lip/Palate
Congenital Birth
Developmental Delays
Diabetes
Ears/Hearing Problems
Eyes/Vision Problems
Gastrointestinal Problems/Acid Reflux
Headaches/Migraines
Heart Murmur
Heart Disease
Hemophilia
Hepatitis
Infections (Viral or Bacterial)
Jaundice
Kidney/Bladder Problems
Learning Disorders
Liver Problems/Biliary Atresia
Lung Problems/Cystic Fibrosis
Pneumonia
Seizures/Epilepsy
Shunts (VP or VA)
Sickle Cell Anemia
Sinus Problems
Skin Problems/Eczema
Sleep Problems
Speech Problems
Thyroid Problems
Tonsil/Adenoid Problems
Transfusions
Transplants
Tuberculosis
Defects/Genetic Disorders
Other

Please describe any items checked above:

_____

_____

_____

Name of school your child is attending:_____

What is your child's favorite sport?_____

DENTAL HISTORY

Reason for this appointment:_____

Is this your child's first visit to the dentist? **Yes** **No**
If no, please list the name of last dentist and date of last visit:_____
Has your child ever had dental radiographs (x-rays)? **Yes** **No**
If yes, please indicate the date of last radiographs:_____

Infant Oral Health
Was your child bottle fed? **Yes** **No** **…If yes, until what age?**_____
Was your child breast fed? **Yes** **No** **…If yes, until what age?** _____

Habits
Did your child use a pacifier? **Yes** **No** **…If yes, until what age?** _____
Did your child suck a finger or thumb? **Yes** **No** **…If yes, until what age?** _____

Oral Hygiene
Does your child brush his/her own teeth? **Yes** **No**
Does your child use dental floss? **Yes** **No**
Do you help your child brush? **Yes** **No**
Do your child's gums bleed when brushed? **Yes** **No**
Did you or your child ever get instructions in brushing/flossing? **Yes** **No**
Does your child use fluoride products: rinses, drops, or tablets? **Yes** **No**

Dental Experience
Has your child experienced an unusual reaction to dental medication or anesthetic? **Yes** **No**
If yes, please explain:_____
Has your child experienced prolonged bleeding following dental treatment? **Yes** **No**
If yes, please explain: _____
Will your child be uncooperative? **Yes** **No**
If yes, please explain: _____
Has your child experienced any complications following dental treatment? **Yes** **No**
If yes, please explain: _____
Is there a history of facial or dental characteristics (ie, missing teeth or jaw surgery) in the family? **Yes** **No**
If yes, please explain: _____
Has your child had any injury to the teeth, jaws or face? **Yes** **No**
If yes, please explain: _____
Has your child experienced any clicking or pain in the jaw joints? **Yes** **No**
If yes, please explain: _____
Does your child wear a mouth guard for sports? **Yes** **No**

Has your child had problems with any of the following (please circle all that apply):

Cavities	**Color of teeth**	**Teeth sensitive to hot/cold**
Toothaches	**Gum infection**	**Teeth sensitive to sweets**
Teeth bumped/chipped	**Grinds teeth**	**Bad breath/halitosis**
Bleeding gums	**Appearance of teeth**	**Alignment of teeth**

Please estimate your child's daily exposure to the following items:

Soda:_____ **Cereal bars/granola bars:**_____
Juice:_____ **Gummies/gummy vitamins:**_____
Sports drinks:_____ **Fruit snacks/fruit roll-ups:**_____
Cookies/crackers:_____ **Dried fruit:**_____

PATIENT NAME: _____

DATE OF BIRTH: _____

FAMILY DENTAL HISTORY

Parent 1: _____

What is your dental decay experience:	**None, Few, Some, Many**	
Did you have braces?	**Yes**	**No**
Have you had any permanent teeth extracted?	**Yes**	**No …if yes, wisdom teeth, premolars, others, don't know**
Have you had periodontal (gum) disease?	**Yes**	**No …if yes, any gum graft?_____**

Parent 2:_____

What is your dental decay experience:	**None, Few, Some, Many**	
Did you have braces?	**Yes**	**No**
Have you had any permanent teeth extracted?	**Yes**	**No …if yes, wisdom teeth, premolars, others, don't know**
Have you had periodontal (gum) disease?	**Yes**	**No …if yes, any gum graft?_____**

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history to provide dental treatment.

PERSON COMPLETING THIS FORM:

Signature: _____ Date: _____

Relationship to Patient: _____ Date: _____

Medical and Dental History reviewed by:_____ Date: _____

McCandless Pediatric Dentistry
455 School Street, Suite 42
Tomball, Texas 77375
281-516-2700
www.teethforkidz.com

Date:_____

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to McCandless Pediatric Dentistry and to consent for any and all recommended dental/medical services.

Legal guardian must bring child to the first dental appointment.

Child(ren) names and date of birth:

_____

_____

_____

_____

Authorized person(s)/Relationship to child(ren):

_____

_____

_____

_____

Parent/Legal Guardian Signature: _____

Printed name:_____

This authorization will remain in effect until changes are made by the parent/guardian as signed above.