Gentle Family Dentistry

bndentist.com

Dear Parents/Guardians:

Welcome to our practice. At ***Gentle Family Dentistry***, we are committed to providing dental care in a most gentle and caring manner. Our goal is to make each visit a very pleasant one and to help teach your child to develop good dental care habits that will keep his or her smile beautiful for a lifetime. As the child's parent/guardian you can help us by talking about the dental visit in a positive manner. Never use dental visits as a threat or punishment and do not make promises about what the dentist will or will not do. We will treat and care for your child as if he/she were our own child. Thank you for entrusting our office to provide your child's dental care.

PATIENT INFORMATION

Name (Last, First, Middle)_____
Preferred Name_____ S.S. #_____ Birthdate _____
Home Address (City, State, Zip) _____ Home Phone_____
School _____ Grade_____
Referred By _____

FAMILY INFORMATION

Person Responsible for This Account

Name (Last, First, Middle)_____ S.S. #_____
Home Address (City, State, Zip) _____ Home Phone _____
Employer _____ Work Phone_____
Dental Insurance Co. _____ Do you have a secondary insurance company? ☐ Yes ☐ No
Relationship to Patient _____ Person to Call for Appointment _____

MEDICAL HISTORY

Please check appropriate response and provide additional detail when applicable.

Child's medical doctor's name _____
Is your child under a doctor's care now? ☐ Yes ☐ No If yes, why? _____
Has your child been hospitalized during the past two years? ☐ Yes ☐ No If yes, why?_____
Is your child taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, list _____
Is your child allergic to any medications or substance? ☐ Yes ☐ No If yes, what?_____

Please check if your child has ever had any of the following:

Heart Trouble	Asthma	Cancer	Psychiatric Care
Rheumatic Fever	Lung Disease	Radiation	Drug Addiction
Heart Murmur	Tuberculosis	Chemotherapy	Blood Transfusion
Diabetes	Liver Disease	Epilepsy	AIDS
Kidney Trouble	Hepatitis A, B, C	Seizures	Sickle Cell Anemia
	Yellow Jaundice	Mitral Valve Prolapse	

Has the child ever had any other serious illness not checked above? ☐ Yes ☐ No If yes, what? _____

DENTAL HISTORY

Please check appropriate response and provide additional detail when applicable.

Does your child have a specific dental problem? ☐ Yes ☐ No If yes, describe _____
Is this your child's first visit to a dentist? ☐ Yes ☐ No
If no, when was his/her last visit to the dentist? _____
Were any x-rays taken on a previous visit to the dentist? ☐ Yes ☐ No ☐ Don't know
Does your child brush daily? ☐ Yes ☐ No If yes, ☐ once ☐ twice ☐ more than twice daily
When does your child brush his/her teeth? ☐ Upon Rising ☐ After Eating Any Food
☐ Right After Meals ☐ Before Going to Bed
Does your child take any fluoride supplement? ☐ Yes ☐ No If yes, what _____
Is your drinking water fluoridated? ☐ Yes ☐ No ☐ Don't know
Do you use bottled water or a water filter? ☐ Yes ☐ No

(OVER)

Has your child had any problem with dental treatment in the past? ☐ Yes ☐ No If yes, describe ______________
____

Has your child ever received a local anesthetic (oral injection)? ☐ Yes ☐ No ☐ Don't know
Does your child need nitrous oxide (laughing gas) for dental treatment? ☐ Yes ☐ No ☐ Don't know
Have you and your child been shown proper dental brushing and flossing? ☐ Yes ☐ No
Does your child suck his/her fingers or have other oral habits? ☐ Yes ☐ No
Does your child use a pacifier? ☐ Yes ☐ No

For Infants/Toddlers:

Does your child take a bottle to bed at bedtime or naptime? ☐ Yes ☐ No
Does your child drink juice or milk or eat snacks after brushing but before bedtime? ☐ Yes ☐ No
Do you brush your child's teeth? ☐ No ☐ Sometimes ☐ Every time
How much tooth paste do you use when brushing your child's teeth? ☐ None ☐ Very little ☐ Some
Do you floss your child's teeth? ☐ No ☐ Sometimes ☐ Every time

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in the child's medical status. I also have read and accept the financial policy of this office.

Signature ______________________________ Date ________________

CLINICAL EXAM

SOFT TISSUE

LIP	N	AB
FRENUM	N	AB
PALATE	N	AB
TONGUE	N	AB
GINGIVA	N	AB

HOME CARE

PLAQUE	L	M	S
TARTAR	L	M	S

XS BITE	N L R
OP-BITE	N M S
O-BITE	N M S
O-JECT	N M S
CLASS	I II III
TOOTH ERUPTION	NORMAL LATE
DECALCIFICATION	NONE YES
CONGENITAL MISSING	NONE YES
CROWDING-U	N M S
CROWDING-L	N M S
SPACING	N M S

DATE	REFERRAL	A/D/W