TEXAS LITTLE TEETH
PEDIATRIC DENTISTRY

12412 S Kirkwood Road, Stafford, Texas 77477. Ph: 832-899-4995

Welcome. We offer you friendship & extraordinary Pediatric Dental & Orthodontic care.

Please fill in your answers as thoroughly as possible. This will help in developing a complete dental health program for your child. Of course, all information will be held in strict confidence.

By working together, we can find a way to achieve your goal of good dental health and beautiful smiles for your child, in ways that transform the quality of life for your child & for you. Come for the dentistry. Stay for the friendship!

PATIENT INFORMATION: Date: _____

Patient's Name:_____ _____
First Middle Last

Nickname_____ Date of Birth___/___/___ Sex: ❑female ❑male

Home Street Address_____ Home Phone Number_____

City_____ Zip_____

School_____ Grade_____

Phone Number for appointment reminder: _____

MOTHER'S NAME_____
First Middle Last

Home Street Address_____ Home Phone Number_____

Social Security Number_____ Mother's DOB _____ Occupation_____

E-mail address _____Employed by_____

Business Address _____Business Phone_____

FATHER'S NAME_____ _____
First Middle Last

Home Street Address_____ Home Phone Number_____

Social Security Number_____ Father's DOB _____ Occupation_____

E-mail address _____Employed by_____

Business Address _____Business Phone_____

Who is your family dentist?_____Office located in what city?_____

Whom may we thank for referring you? _____

Referring address _____

- **Federal law requires that the parent or guardian who brings the child to appointments is responsible for the incurred fees.**
- **I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.**
- **I certify this information is true and correct to the best of my knowledge.**
- **I will notify you of any changes in my child's health status or the above information.**
- **I understand Doyle & Baker, PSC files insurance claims electronically. This is acceptable to me.**
- **I have received my brochure about my privacy rights (HIPAA) and how my information can be used.**

_____ Date_____
Signature relationship to patient

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DENTAL HEALTH:

Why did you bring your child to the dentist today?_____

How long has it been since your child's last dental exam?_____last tooth cleaning?_____ ❑First visit ever

For most drinking & cooking do you use: ❑town water ❑well-water ❑bottled water

If well or bottled, has water been tested for fluoride?.....❑No ❑Yes

Results? _____

Does your child take fluoride supplements?.....❑Yes ❑ No

Dose_____Frequency_____

Have there been any injuries to the face, mouth or teeth?.....❑Yes ❑ No

Please give dates and descriptions_____

_____

Has your child ever sucked a thumb or fingers?.....❑Yes ❑ No

Pacifier?.....*❑Yes ❑ No

Any other habits?_____ For thumb, pacifier or other habits until what age?_____

Does your child have:

- Snoring .....*❑Yes ❑ No
- Daytime mouthbreathing .....*❑Yes ❑ No
- Nighttime mouthbreathing .....*❑Yes ❑ No
- Tooth grinding .....*❑Yes ❑ No
- Bedwetting now .....*❑Yes ❑ No
- Hearing deficiency .....*❑Yes ❑ No
- Frequent middle ear infections .....*❑Yes ❑ No
- Environmental allergies .....*❑Yes ❑ No
  - Taking medications?_____
- History of sleep apnea.....*❑Yes ❑ No
- Restless Sleep ..... *❑Yes ❑ No
- Speech problems .....*❑Yes ❑ No

Have you been informed of any missing or extra permanent teeth?..... ❑Yes ❑ No

Are there any unusual sounds in ear (clicking) during eating? ..... ❑Yes ❑ No

Has your child ever had an orthodontic examination or orthodontic treatment?..... ❑Yes ❑ No

Does your child use a sippy cup? .....*❑Yes ❑ No

Did your child go to sleep with a bottle, with a sippy cup, or while nursing ?.....*❑Yes ❑ No

Until what age?_____

Is your child nervous or frightened during dental visits? If yes, please circle

Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.

_____

Has your child had any unfavorable medical or dental experience?.....❑Yes ❑No

If so, please explain_____

How will you describe your child's temperament (please circle one):

Easy or Flexible Active or Feisty Slow to warm or Shy Other _____

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MEDICAL HEALTH:

Is your child in good health?..... ❑No ❑Yes

Date of last physical examination_____

Is your child now under the care of a physician?..... ❑Yes ❑No

If so, what is the condition being treated?_____

Did your child have trouble at birth or during the early years?..... ❑Yes ❑No

Please describe_____

Name of Pediatrician or Family Physician_____

Address & Phone _____

Has your child had any serious illness or injury?..... ❑Yes ❑No

If so, what was the illness or injury? _____Date_____

Was your child delivered by Caesarean Section?..... ❑Yes ❑No

Has your child ever been hospitalized or had surgery? ..... ❑Yes ❑ No

DATE_____REASON:_____

DATE_____REASON:_____

Have your child's tonsils or adenoids been removed? ..... ❑Yes ❑ No

If yes, when_____

What is the teeth decay rate of your child's siblings? ❑none ❑slight ❑moderate ❑severe

Does your child have or has your child had any of the following?

Rheumatic fever or rheumatic heart disease	❑Yes ❑No	Tuberculosis	❑Yes ❑ No
Heart murmur	❑Yes ❑ No	Mononucleosis	❑Yes ❑ No
Congenital heart lesions	❑Yes ❑ No	Low blood pressure	❑Yes ❑ No
(heart abnormalities present since birth)	❑Yes ❑ No	Thyroid problem	❑Yes ❑ No
Physician has recommended antibiotics before dental procedures	❑Yes ❑ No	Anemia	❑Yes ❑ No
Other cardiovascular Disease	❑Yes ❑ No	Bone disorders	❑Yes ❑ No
Environmental allergies	*❑Yes ❑ No	Growth problems	❑Yes ❑ No
Hay fever or sinus problems	*❑Yes ❑ No	Stomach ulcers	❑Yes ❑ No
Asthma or breathing problems	*❑Yes ❑ No	Kidney problems	❑Yes ❑ No
Hives or skin rash	❑Yes ❑ No	Birth defect (please describe):_____ _____	
Fainting spells or seizures	❑Yes ❑ No	Hearing problems	❑Yes ❑ No
Diabetes	❑Yes ❑ No	Learning problems	*❑Yes ❑ No
Hepatitis, jaundice or liver problems	❑Yes ❑ No	Behavior problems	*❑Yes ❑ No
(if jaundice, when newborn?)	❑Yes ❑ No	Mental/emotional problems	❑Yes ❑ No
Arthritis	❑Yes ❑ No	Blood transfusion	❑Yes ❑ No
Limits on physical activities	❑Yes ❑ No	HIV (AIDS)	❑Yes ❑ No
		Other _____	❑Yes ❑ No

Has your child had abnormal bleeding with previous extractions, surgery, or trauma? ..... ❑Yes ❑ No

Has your child been tested for sickle cell anemia? ..... ❑Yes ❑ No

If yes, what was the result?_____

Does your child take any drug or medicine? ..... ❑Yes ❑ No

If so, what/how often_____

Does your child take any vitamins, supplements? ..... ❑Yes ❑ No

Please list:_____

Has your child ever had an allergic reaction to:(if yes, please describe)_____

Aspirin or Ibuprofen	Yes	No	Codeine	❑Yes	❑ No
Penicillin or other antibiotics	Yes	No	Sulfa drugs	❑Yes	❑ No
Novocaine, Xylocaine or			Foods	❑Yes	❑ No
other local anesthetics	Yes	No	Latex	❑Yes	❑ No

Other_____

Does your child use any complementary or alternative medicines or supplements? .....❑Yes ❑ No

Please list _____

Does your child have any mental or physical disability? .....❑Yes ❑ No

If so, please explain_____

Does your child have any disease, condition or problem not listed above that you think we should know about?

_____

What are her/his hobbies or interests?

_____

Thank you very much!

Name of Parent/ Guardian _____

Signature of Parent/Guardian _____

Relationship to Patient _____

Date: _____

CONSENT:

I. The undersigned hereby authorizes the taking of x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. ____ to make a thorough diagnosis of your child's dental orthodontic needs.

2. I also authorize Dr. _____ to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment of my child.

3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. _____ choose and employ such assistance as deemed fit to provide recommended treatment.

Name of Parent/ Guardian _____

Signature of Parent/Guardian _____

Relationship to Patient _____

Date: _____