Riverbend Pediatric Dentistry LLC
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Demographic Information

Patient: _____ Today's Date_____
Name child would like to be called_____ Home Phone_____
Birthday_____/_____/_____ Age_____ Gender: M F Cell Phone_____
Guardian's Email(s) _____
Home Address_____
street town state zip code
Siblings that we treat: _____
School: _____ Grade _____

Parent/Legal Guardian: _____ Relation to patient:_____
Employer: _____ Phone:_____
Parent/Legal Guardian: _____ Relation to patient:_____
Employer: _____ Phone: _____
Who has legal custody of patient?_____ Dental Insurance: ☐ Yes ☐ No
Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____

Name of child's physician/group_____City/St:_____Ph #:_____

Health History

☐ Yes ☐ No Is your child in good health? Date of last physical exam_____
☐ Yes ☐ No Is your child being treated by a physician at this time?
Reason: _____
☐ Yes ☐ No Has your child ever had a health problem?_____
☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_____
_____
☐ Yes ☐ No Is your child allergic to anything including medications?
List: _____
☐ Yes ☐ No Is your child currently taking any medications? Please give medication, dose and reason_____
_____
☐ Yes ☐ No Has your child ever had a reaction to or problem with anesthetics?
List:_____
☐ Yes ☐ No Were there any problems before or at birth?_____
☐ Yes ☐ No Is your child up to date on immunizations against childhood disease?

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last xrays (if taken)_____
Name of dentist and date_____
☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care?
Explain_____
☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?
☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?
☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

☐ Cavities ☐ Toothache ☐ Sensitive Teeth
☐ Trauma ☐ Gum Infections ☐ Color of teeth
☐ Orthodontics ☐ Jaw Sounds ☐ Other

Office Use Only
☐ Fl- City Water
☐ Pvt. Well
☐ Public Well _____ppm
☐ H_2O test kit given

Please check if your child has been treated for any of the following:

- ○ Abuse (mental, physical, emotional, sexual)
- ○ Asthma
- ○ Frequent cough/cold
- ○ ADD/ ADHD
- ○ Adverse drug reactions
- ○ Autism
- ○ Behavioral problems
- ○ Personality/Social Disorder
- ○ Mental Delay
- ○ Physical Delay
- ○ Bladder or Kidney Problems
- ○ Blood Disorders (anemia, sickle cell)
- ○ Hemophilia, bruising easy, excessive bleed
- ○ HIV/AIDS
- ○ Bone, Muscle, Joint Problems
- ○ Cancer
- ○ Cleft Lip / Palate
- ○ Congenital Heart Defect/Disease
- ○ Congenital Birth Defects
- ○ Cystic Fibrosis
- ○ Cerebral Palsy
- ○ Developmental Disorders
- ○ Dietary Restrictions
- ○ Diabetes
- ○ Endocrine
- ○ Epilepsy / Seizures
- ○ Frequent Infections
- ○ Headaches (frequent/recurrent)
- ○ Hormonal Problems
- ○ Hydrocephaly or placement of a shunt
- ○ Jaundice, Hepatitis or Liver Problems
- ○ Sexually Transmitted Diseases
- ○ Skin Problems (hives, rash)
- ○ Speech/Hearing/Vision Problems
- ○ Stomach or Intestinal Problems
- ○ Thyroid or Pituitary Problems
- ○ Other (please specify)

Provide Details Here: _____

_____

_____

Is there any other significant medical history pertaining to this child or his/her family that they dentist should be told?
Y / N If Yes, describe: _____

_____

_____

Do you consider your child to be
- □ advanced in the learning process
- □ progressing normally
- □ slow in the learning process

Was your child □ breast fed □ bottle fed at what age was it stopped? _____

Fluoride History

- □ Yes □ No Is your home water supply fluoridated?
- □ Yes □ No Does your child use fluoride toothpaste?
- □ Yes □ No Do you give your child any other form of fluoride? What? _____
- □ Yes □ No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Snyder to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Snyder to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Snyder will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ **Date** _____
Parent or Legal Guardian

Printed Name: _____
Parent or Legal Guardian

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Please take a few moments to answer these questions about your child's oral and dental health. By providing accurate information, it allows us as dental health care professionals to identify your child's individual risk for developing cavities and create a home care plan to better prevent cavities from developing and maintain a beautiful smile!

Dental History

Providing an accurate dental history is an important part of our exam. Please check the following that apply to your child:

Previous Dental Visits
___ this is patient's first visit to dentist
___ patient has previously seen a dentist for check-ups &/or treatment (fillings, etc)
___ patient was previously seen by a dentist and referred to Riverbend Pediatric Dentistry for care

History of Cavities
___ patient has no previous history of dental cavities
___ patient has a history of dental cavities

___ no family history of cavities
___ family history of caries - parents have active cavities
___ family history of caries - parents have history of cavities
___ family history of caries - siblings have active cavities
___ family history of caries - siblings have history of cavities

Home Care / Fluoride Exposure
___ patient receives adequate home care, brushing teeth at least twice per day with fluoride toothpaste
___ patient receives less than recommended daily oral care

___ patient's teeth are flossed on a regular basis
___ patient's teeth are not flossed on a regular basis

___ patient spends most of their time in an environment with adequately fluoridated water
___ patient spends most of their time in an environment that does not have adequately fluoridated water

Diet
___ patient's diet exposes them to a minimal amount of sugar
___ patient's diet exposes them to a moderate amount of sugar
___ patient's diet exposes them to a high amount of sugar

___ patient drinks predominantly low sugar drinks (mainly water)
___ patient has heavy intake of sugary drinks

Oral Habits
___ no oral habits present
___ oral habit present - finger habit
___ oral habit present - pacifier habit

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Caries Risk Assessment

The following questions are taken from the American Academy of Pediatric Dentistry & the American Dental Association's tools that help to identify individual risk factors for developing dental cavities. More accurate answers ensure that we can provide the necessary recommendations for adequate preventive measures. Please check those biological and protective factors that apply to your child.

Biological Factors (to be completed by the parent/guardian)

- High Risk Factors
  - ☐ Mother/primary caregiver has active cavities
  - ☐ Parent/caregiver has low socioeconomic status
  - ☐ Child has >3 between meal sugar-containing snacks or beverages per day
  - ☐ Child is put to bed with a bottle containing natural or added sugar
- Moderate Risk Factors
  - ☐ Child has special health care needs
  - ☐ Child is a recent immigrant

Protective Factors (to be completed by the parent/guardian)

- ☐ Child receives optimally fluoridated drinking water
- ☐ Child has teeth brushed daily with fluoride toothpaste
- ☐ Child receives topical fluoride from health professional
- ☐ Child has dental home/regular dental care

Do not write below this line – for Riverbend Pediatric Dentistry staff use only

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Clinical Findings (to be completed by dentist during clinical exam)

- ☐ Child has >1 decayed/missing/filled surfaces
- ☐ Child has active white spot lesions or enamel defects
- ☐ Child has plaque on teeth
- ☐ Dental/Orthodontic Appliances present
- ☐ Inadequate salivary flow

Caries Risk: **Low** **Moderate** **High**