SpringRockDental

Child Patient Health Form

Date:

Patient Name: **Date of Birth:**

Medicaid #: **KP MRN:** **Guardian (if applicable):**

Patient Dental History (for children under 18 years)

Why are you visiting our office today? Exam X-rays Cleaning Other:

Is this your child's first visit to a dentist? Yes No

If No, Date of Last Dental Visit: Dentist Name:

Approximate Date of Last Dental X-rays: Dentist Phone #:

Does your child have any dental problems that you are aware of? Yes No

Has your child ever had any major dental problems in the past? Yes No

If yes, please explain:

If yes, please explain:

Do they get sores/ulcers in/around their mouth?	Yes. Explain: No
Have they had a serious injury to your mouth/head?	Yes. Explain: No
Do they have fears with dental treatment?	Yes No
Do their gums bleed when brushing or flossing?	Yes No
Do they have teeth that are sensitive to:	Hot Cold Chewing Sugar
Do they have dry mouth problems?	Yes No
Are they a mouth breather?	Yes No
Have they had gum treatments like deep cleaning or surgery?	Yes No
Have they had braces or other orthodontic treatment?	Yes No When:
Do they have a pop, clicking or cracking noise in their jaw?	Yes No
Do they have pain in their jaw joint?	Yes No
Do they grind, grit, or clench their teeth (while awake or asleep)?	Yes No
Does your child use:	Mouthwash Fluoride mouthwash
Does your child have the following:	Migraines Headaches Noises in ears
Are they allergic to dental anesthetic?	Yes No

Family Dental History

Do any dental problems run in your family?	Yes. Explain: No
Please rank the following family members' decay history, based on past or present cavities:	Mother: Many Few None Father: Many Few None Siblings: Many Few None

Continued

Cavity Prevention History

Question	Response
Does your child receive fluoride daily?	Yes (water) Yes (supplement) No
Does your child use a toothpaste containing fluoride?	Yes No
How often are your child's teeth brushed daily?	1 2 3+
What type of toothbrush does your child use?	Manual Electric Battery
Who brushes your child's teeth?	Child Parent Other
How often are your child's teeth flossed?	Daily Occasionally Never
What does your child use to floss?	Floss Flosspicks Waterpik
Did you know you should help brush your child's teeth until he or she is 7 years old?	Yes No
How often does your child drink soda, sports drinks, juice?	Daily Once a week Other
Does your child have any oral habits (sucking thumb, finger, pacifier, etc.)?	Yes No. Explain:
Does your child sleep with a bottle?	Yes No
If yes, what's in bottle?	

Medical History

Question	Response
Has your child had an orthopedic total joint replacement? (hip, knee, etc.)	Yes. When: No Complications?
Is your child taking or scheduled to begin taking either of the following medications: alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	Yes. When began? No
Since 2001, has your child been treated or are they presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hyperkalemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	Yes. Explain: No
Does your child use medical marijuana?	Edibles Oil Cream Smoke Vapor Other
Is your child currently in treatment for cancer?	Yes Cancer type: No Treatment:
Has your child had, or do they currently have any of the following conditions?	Heart murmur: Yes No Last heard: Heart trouble: Yes No Diabetes Yes No Congenital heart disease (CHD)? Yes No Epilepsy, convulsions, or fainitng spells: Yes No Any serious illness not listed Yes No
Has a physician or previous dentist recommended that your child take antibiotics prior to your dental treatment?	Yes Explain: No

Continued

Other History

Does your child drink alcohol or use recreational drugs?	Yes No
Has your child ever used drugs other than those required for medical reasons?	Yes No
Does your child smoke cigarettes? If yes, how often?	Yes No How often?
Does your child use chewing tobacco? If yes, how often?	Yes No How often?
Has a physician or previous dentist recommended that your child takes antibiotics prior to dental treatment?	Yes No
Are they allergic to or have any medication reactions?	Yes Explain: No
Please list any current medications your child is taking:	

This is an annual form, and you will be asked to complete it each year for your child.

I, ______________________________, acknowledge that my child will receive an oral hygiene examination,
PRINT Name of Parent/Guardian
diagnosis treatment plan, and treatment from a registered dental hygienist (RDH) licensed in Colorado. I acknowledge that I will continue my oral hygiene maintenance in collaboration with a dentist and that a dentist should perform a dental examination twice yearly.

Patient/Parent/Guardian Signature: **Date:**

RDH Signature: **Date:**

Reviewed Entered into Patient Chart Scanned

OFFICE NOTES: REF CU PAIN ASAP OG REF DDS REF KP RXABX RXPAIN PREMED? KPPT NVSCRP4QFULL NVLTD SCRP PHOTOSNV PARMEDI PARDELTA PARCIGNA PAROTHER HIGHRISK-F-PAR SEALANTPAR CI C2 C3 C4 ?72/106