BLOSSOM

Welcome to Blossom Pediatric Dentistry and Orthodontics

Patient Information:

Today's Date:

Child's Name _____ Nickname _____

Birthday _____ Age _____ Birth Gender: _____ Gender Identity: _____

Home Address _____ State/City/Zip _____

Parent/Guardian Information:

Your Name _____ Relationship to child _____

Are you the legal guardian? **Y N** If no, name of legal guardian _____

Parent/Guardian Name _____ Parent/Guardian Name _____

Relationship to child _____ Relationship to child _____

Home Phone # _____ Cell Phone # _____ Home Phone # _____ Cell Phone # _____

Address _____ Address _____

Occupation _____ Employer _____ Occupation _____ Employer _____

Email _____ Email _____

SSN _____ DOB _____ SSN _____ DOB _____

Parent/Guardian marital status: **Single Married Divorced Separated Widowed Domestic Partners**

Is your child adopted? **Y N**

Do you have other children who are seen in our office? **Y N**

Whom may we thank for referring you to our office? _____

Primary Insurance:

Subscriber's Name _____

Insurance Co. _____

Subscriber ID _____ Group # _____

Company Phone: _____

Company Address: _____

Primary Insurance:

Subscriber's Name _____

Insurance Co. _____

Subscriber ID _____ Group # _____

Company Phone: _____

Company Address: _____

BLOSSOM
Pediatric Dentistry & Orthodontics

Medical History:

Child's Name _____

Does your child have a history of, or currently have any of the following:

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Autism Spectrum
- ☐ Behavioral Issues
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cleft Lip/Palate
- ☐ Cerebral Palsy
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ GERD/Acid Reflux
- ☐ Heart Problems/Murmur
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hospitalization/Surgery
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Premature Birth
- ☐ Respiratory Problems
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell Anemia/Trait
- ☐ Vision Impairment

Please explain any of the above indicated, or any other serious conditions not listed:

_____

_____

Is there anything you would like to discuss with the doctor in private?

_____

_____

Please list all medications your child is taking:

_____

_____

Please list any allergies:

_____

_____

Child's Physician _____

Phone # _____

Is your child up to date with immunizations? Y N

Dental and Oral Health History:

Is this your child's first dental visit? Y N

If no, who was the previous dentist? _____

Date of last visit? _____

Does your child have a toothache or any other immediate concern? Y N

Is there a history of trauma to the mouth, teeth, or jaw? Y N

Do you anticipate your child having difficulty with dental treatment? Y N

If yes, why? _____

Does your child have any oral habits?

- ☐ Grinding
- ☐ Mouth breathing
- ☐ Nail biting
- ☐ Other

Does your child currently, or have a history of sucking habits?

- ☐ Pacifier
- ☐ Finger
- ☐ Other

Does your child brush their teeth daily? Y N
Floss? Y N

Does anyone assist with brushing? Y N

Does your child use a fluoridated toothpaste? Y N

Any history or current use of fluoride supplements? Y N

Does your child drink:

- ☐ City water
- ☐ Well water
- ☐ Bottled water

If bottled, what brand? _____

Did/Does your child: Breast feed? Y N
Until what age? _____

Bottle feed? Y N Until what age? _____

Does your child have any dietary restrictions? Y N

Parent/Guardian Name: _____

Parent/Guardian Signature: _____