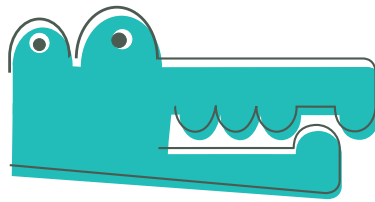


NEW ORLEANS CHILDRENS DENTAL CENTER



WELCOME NEW PATIENT

PATIENT INFORMATION:

PATIENT NAME: NICKNAME:

DATE OF BIRTH: SEX: HOME PHONE:

ADDRESS: CITY: STATE: ZIP:

PARENT OR GUARDIAN NAME:

SCHOOL: GRADE:

SIBLINGS: (NAMES & AGES)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE:

PARENT'S INFORMATION:

PARENT'S MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ REMARRIED ☐ SINGLE

MOTHER'S NAME: BIRTHDATE:

ADDRESS: CITY: STATE: ZIP:

HOME NO: WORK NO: CELL NO:

EMPLOYER: OCCUPATION:

DRIVERS LICENSE NO: SOCIAL SECURITY NO:

EMAIL:

FATHER'S NAME: BIRTHDATE:

ADDRESS: CITY: STATE: ZIP:

HOME NO: WORK NO: CELL NO:

EMPLOYER: OCCUPATION:

DRIVERS LICENSE NO: SOCIAL SECURITY NO:

EMAIL:

DENTAL INSURANCE INFORMATION:

1. INSURED'S NAME: SOCIAL SECURITY NO: DOB:

GROUP NAME: GROUP POLICY NO:

INSURANCE COMPANY NAME: PHONE NO:

ADDRESS: CITY: STATE: ZIP:

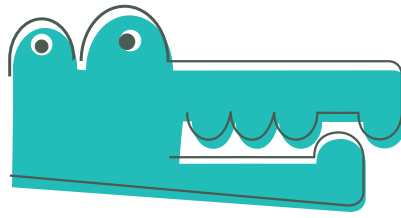
2. INSURED'S NAME: SOCIAL SECURITY NO: DOB:

GROUP NAME: GROUP POLICY NO:

INSURANCE COMPANY NAME: PHONE NO:

ADDRESS: CITY: STATE: ZIP:

NEW ORLEANS CHILDRENS DENTAL CENTER



MEDICAL HISTORY QUESTIONNAIRE

CHILD'S MEDICAL HISTORY:

PATIENT NAME: CHILD'S PHYSICIAN: DATE OF LAST VISIT:

ARE IMMUNIZATIONS CURRENT? ☐ YES ☐ NO

IS YOUR CHILD UNDER MEDICAL CARE AT PRESENT? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS? PLEASE CHECK OFF ALL THAT APPLY:

- | | | | |
|---|--|---|--|
| ☐ ADD/ADHD | ☐ CHRONIC SINUS INFECTIONS | ☐ HEART DISEASE | ☐ RHEUMATIC FEVER |
| ☐ ALLERGIES | ☐ CHRONIC EAR INFECTIONS | ☐ HEART MURMUR | ☐ SICKLE CELL DISEASE |
| ☐ ANEMIA | ☐ CYSTIC FIBROSIS | ☐ HEART DEFECTS | ☐ SICKLE CELL TRAIT |
| ☐ ANXIETY/DEPRESSION | ☐ SEIZURES/EPILEPSY | ☐ HEMOPHILIA | ☐ TUBERCULOSIS |
| ☐ ASTHMA | ☐ DEVELOPMENTAL DELAY | ☐ KIDNEY PROBLEMS | ☐ NEUROLOGICAL PROBLEMS |
| ☐ AUTISM/ASPERGER | ☐ DIABETES | ☐ LIVER PROBLEMS | ☐ ORTHOPEDIC PROBLEMS |
| ☐ BLEEDING DISORDERS | ☐ DOWN SYNDROME | ☐ LUNG PROBLEMS | ☐ EYE PROBLEMS |
| ☐ CANCERS | ☐ HIV/AIDS | ☐ PSYCHIATRIC TREATMENTS | ☐ ACID REFLUX |
| ☐ CEREBRAL PALSY | ☐ HEPATITIS | ☐ SPEECH/HEARING PROBLEMS | ☐ EMOTIONAL DISTURBANCES |
| ☐ CLEFT LIP/PALATE | ☐ MENTAL RETARDATION | ☐ BIRTH DEFECTS | |
| ☐ HIGH BLOOD PRESSURE | ☐ LEARNING DISABILITIES | ☐ PREMATURE BIRTH | |

DOES YOUR CHILD HAVE ANY OTHER DISEASES, CONDITIONS, OR SYNDROMES NOT LISTED ABOVE? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:

IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? ☐ YES ☐ NO

IF YES, PLEASE LIST:

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO IF YES, PLEASE LIST:

HAS YOUR CHILD EVER BEEN SEDATED OR HAD GENERAL ANESTHESIA? ☐ YES ☐ NO IF YES, WHAT FOR?

HAS YOUR CHILD EVER HAD SURGERY OR BEEN HOSPITALIZED? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:

IS YOUR CHILD HAVING ANY DIFFICULTIES IN SCHOOL? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:

DO YOU CONSIDER YOUR CHILD TO BE:

☐ ADVANCED IN LEARNING ☐ PROGRESSING NORMALLY ☐ A SLOW LEARNER

IS THERE ANYTHING WE SHOULD KNOW ABOUT YOUR CHILD?

IS THERE ANYTHING ABOUT YOUR CHILD YOU WOULD LIKE TO DISCUSS IN PRIVATE? ☐ YES ☐ NO

CHILD'S DENTAL HISTORY:

PLEASE CHECK OFF REASON(S) FOR SEEKING DENTAL CARE:

- ☐ FIRST EXAMINATION ☐ ROUTINE CHECK-UP ☐ TOOTHACHE OR SWELLING ☐ CAVITIES
☐ APPEARANCE OF TEETH ☐ CROWDING ☐ ACCIDENT/INJURY

OTHER: _____

HAS YOUR CHILD BEEN TO A DENTIST PREVIOUSLY? ☐ YES ☐ NO

WHEN: _____ WHERE: _____

WERE X-RAYS TAKEN: ☐ YES ☐ NO ☐ NOT SURE

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS:

- ☐ THUMB/FINGER SUCKING ☐ MOUTH BREATHING ☐ PACIFIER ☐ SNORING
☐ BOTTLE/SIPPY CUP ☐ LIP SUCKING/BITING ☐ GRINDING/CLENCHING

DOES YOUR CHILD HAVE FLUORIDE IN ANY OF THE FOLLOWING FORMS:

- ☐ TOOTHPASTE ☐ DRINKING WATER ☐ HOME FLUORIDE RINSES/GELS/VARNISH ☐ FLUORIDE TABLETS/VITAMINS

WHAT TYPE OF WATER DOES YOUR CHILD DRINK: _____

IS YOUR CHILD STILL BREAST FED OR USING A BOTTLE/SIPPY CUP? ☐ YES ☐ NO

IF NO, WHAT AGE WAS IT STOPPED? _____ FREQUENCY OF TOOTH BRUSHING? _____

FLOSSING? _____ WHO DOES THE BRUSHING? ☐ CHILD ☐ PARENT/GUARDIAN

HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT? (CHECK ALL THAT APPLY)

- ☐ OUTGOING ☐ SHY ☐ STUBBORN ☐ ANXIOUS ☐ FRIGHTENED ☐ REGULAR KID
☐ CURIOUS ☐ MOODY ☐ FRIENDLY ☐ DEFIANT ☐ HIGH STRUNG ☐ COOPERATIVE

HAS YOUR CHILD EVER EXPERIENCED ANY PROBLEMS OR COMPLICATIONS FROM PREVIOUS DENTAL CARE? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

CONSENT:

THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZE DR. CAVALLINO AND DR. AXELRAD TO COMPLETE A DENTAL EVALUATION AND PERFORM THE NECESSARY DENTAL SERVICES FOR MY CHILD.

SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

OFFICE USE ONLY:

SUMMARY: _____

SBE PROPHYLAXIS REQUIRED ☐ YES ☐ NO PRECAUTIONS: _____

INITIALS OF REVIEWING DENTIST: _____ DATE: _____