PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

955 Main Street, Suite 101 | Winchester, MA 01890 | 781-729-1900
54 Haven Street | Reading, MA 01867 | 781-944-7799
www.pdadentalgroup.com

Patient's Last Name _____ Patient's First Name _____ Middle Initial _____ Nickname _____

Gender Identity: She/Her He/Him They/Them

Birthdate _____ Home Phone Number _____

Home Address: Street _____ City _____ State _____ Zip Code _____

Legal Guardian #1 Name _____ Birthdate _____ Social Security # _____ Cell Phone Number _____

Legal Guardian #1 Occupation/Employer _____ Email Address _____ Relationship to Patient _____

Legal Guardian #2 Name _____ Birthdate _____ Social Security # _____ Cell Phone Number _____

Legal Guardian #2 Occupation/Employer _____ Email Address _____ Relationship to Patient _____

Martial Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Name and Ages of Siblings _____ Previous Dentist _____ Pediatrician _____

Do you want to give us permission to speak to anyone else about your family's treatment or bill? ☐ Yes ☐ No
If yes, please specify who: _____

How did you hear about us? ☐ Referral ☐ Social Media/Internet ☐ Community Event ☐ Family/Friends ☐ Pediatrician ☐ PDA Employee
Whom may we thank for referring you? _____

MEDICAL HISTORY

1) History:
- Were there any difficulties during pregnancy, delivery or first year of life? ☐ **Yes** ☐ **No**
  If yes, please explain: _____
- Was your child premature? ☐ **Yes** ☐ **No**
- Was your child adopted? ☐ **Yes** ☐ **No**
  If yes, does your child know? _____
- Is a physician treating your child now for any specific illnesses? ☐ **Yes** ☐ **No**
  If yes, please explain: _____
- Are your child's immunizations up to date? ☐ **Yes** ☐ **No**
- Have antibiotics ever been recommended for your child before a dental visit? ☐ **Yes** ☐ **No**
  If yes, please explain: _____
- Does your child frequently get cold sores? ☐ **Yes** ☐ **No**

2) Hospitalizations:
- Has your child ever been hospitalized, had an operation or has an upcoming operation? ☐ **Yes** ☐ **No**
  If yes, please explain: _____
- Was general anesthesia used? ☐ **Yes** ☐ **No**
  If yes, any complications (ie. Malignant hyperthermia)? _____

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3) Medications:

- Is your child taking any medication at this time? ☐ **Yes** ☐ **No**

If yes, please list below.

MEDICATION NAME	HOW MUCH?	HOW OFTEN?	REASON?

- Has your child taken any medications in the past? ☐ **Yes** ☐ **No**

If yes, please explain: _____

4) Allergies: Does your child have any allergies or unusual reactions to any of the following?

- Latex ☐ **Yes** ☐ **No** If yes, please explain: _____
- Medications ☐ **Yes** ☐ **No** If yes, please explain: _____
- Food ☐ **Yes** ☐ **No** If yes, please explain: _____
- Other ☐ **Yes** ☐ **No** If yes, please explain: _____

5) Development & Special Needs:

- Does your child have difficulty talking and understanding at their age level? ☐ **Yes** ☐ **No**
- Does your child attend a special class, school or services? ☐ **Yes** ☐ **No**
- Does your child use a wheelchair/walker for transportation? ☐ **Yes** ☐ **No**

If yes, please specify: _____

6) Medical Conditions: Does your child have any history of the following? (Please check all that apply)

☐ **Cardiac Disorders (Heart Related)**
- ☐ Congenital Heart Disease
- ☐ Previous Bacterial Endocarditis
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ High Blood Pressure

☐ **Lung/Airway Disease**
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Adenoid/Tonsil Problems
- ☐ Chronic Ear Infections

☐ **Endocrine Disorders (Hormone Related)**
- ☐ Diabetes
- ☐ Hyper/Hypothyroidism
- ☐ History of Steroids

☐ **Gastrointestinal Disorders (Stomach Related)**
- ☐ Acid Reflux / GERD
- ☐ Nutritional Deficiency
- ☐ Inflammatory Bowel Disease (ie. Crohns)

☐ **Musculoskeletal Concerns**
- ☐ Joint Replacement

☐ **Substance Use**
- ☐ Tobacco
- ☐ Alcohol
- ☐ Drug: _____

☐ **Kidney or Bladder Problems**

☐ **Liver Disease**

☐ **Hematologic Concerns (Blood Related)**
- ☐ Hemophilia
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Transfusion of Blood

☐ **Infectious Diseases**
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Venereal Diseases (ie. Herpes, HPV):
  List: _____

☐ **Behavior & Learning Concerns**
- ☐ ADHD (ADD)
- ☐ Behavior Issues:
  List: _____
- ☐ Eating Disorder:
  List: _____
- ☐ Emotional/Psychiatric Disorder:
  List: _____
- ☐ Learning Disability:
  List: _____
- ☐ Speech Delay/Problems

☐ **History of Abuse (physical/psychological)**

☐ **Growth & Developmental Disorders**
- ☐ Autism Spectrum Disorder
- ☐ Anxiety/Nervousness
- ☐ Brain Injury/Cerebral Palsy
- ☐ Congenital Birth Defects
- ☐ Cleft Lip/Palate
- ☐ Depression
- ☐ Developmental Delay (Physical/Mental)
- ☐ Fainting/Dizziness/Frequent Headaches
- ☐ Feeding/Eating Problems
- ☐ Hearing Problems:
  List: _____
- ☐ Neuromuscular Defect
- ☐ Seizure History/Epilepsy
- ☐ Vision Problems

☐ **Miscellaneous**
- ☐ Cancer/Malignancies:
  List: _____
- ☐ Syndrome:
  List: _____

☐ **Additional Comments:** _____

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DENTAL HISTORY

1) Why is your child here today? _____

2) Dental History:
- Has your child been to a dentist previously? ☐ Yes ☐ No
  If yes, when was the last visit? _____
- Have x-rays been taken? ☐ Yes ☐ No
  If yes, when and what type of x-rays? _____
- Has your child had local anesthetic (Novocaine)? ☐ Yes ☐ No
  If yes, were there any problems? _____
- Does a Parent/Sibling/Primary Caregiver have a history of cavities? ☐ Yes ☐ No
- Did your child have a difficult/traumatic experience their previous provider? ☐ Yes ☐ No
- How would you describe your child's dental experience?
  ☐ Outgoing ☐ Cooperative ☐ Stubborn ☐ Anxious ☐ Shy ☐ Frightened ☐ Curious ☐ Friendly ☐ Defiant
- How do you think your child will react to dental treatment? _____

3) Fluoride: Has your child had fluoride in any of the following forms?
- Fluoride tablets/supplements ☐ Yes ☐ No If yes, please circle: 0.25mg 0.5mg 1.0mg
- Toothpaste ☐ Yes ☐ No If yes, please list brand: _____
- Fluoride rinse/gel ☐ Yes ☐ No If yes, please list brand: _____
- Drinking water (community water fluoridation) ☐ Yes ☐ No
- In-Office fluoride varnish/treatment at dentist/pediatrician ☐ Yes ☐ No If yes, date of last application: _____

4) Brushing:
- Does your child brush their own teeth? ☐ Yes ☐ No
- When do they brush? ☐ AM ☐ PM
- Do you help brush your child's teeth? ☐ Yes ☐ No
- Does your child use dental floss in cleaning their teeth? ☐ Yes ☐ No

5) Diet:
- Does your child have greater than 3 sugary snacks or beverages between meals? ☐ Yes ☐ No
  If yes, what do those snacks usually consist of? _____
- How much soda/juice/energy drinks does your child usually drink per day? _____

6) Trauma: Have your child's teeth ever been injured? ☐ Yes ☐ No
  If yes, age when injured? _____ Which teeth? _____ Cause of injury? _____
- Did your child receive treatment? ☐ Yes ☐ No
  If yes, describe the treatment? _____

7) Habits: Does your child have any of the following habits? Check all that apply.
☐ Bottle to bed/nap time ☐ Breastfeeding ☐ Thumb/Finger sucking ☐ Pacifier ☐ Mouth breathing ☐ Grinding of teeth
☐ Excessive gagging ☐ Other _____

8) Has your child received any unusual dental or surgical treatments to the mouth? ☐ Yes ☐ No
If yes, please specify: _____

9) Is there anything else you would like to tell us about your child's dental history? ☐ Yes ☐ No
If yes, please specify: _____

I certify that I have read and understand this information to the best of my knowledge. The questions have been accurately answered. It is my responsibility to inform the office of any changes in medical status. I hereby give permission to PDA Dental Group to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, cleanings, exams, topical and local anesthetics (injections), fillings, radiographs, etc.

Responsible Party's Signature _____ **Date** _____