Welcome to Anantuni Family Pediatric Dentistry. Our staff would like to welcome you and your child to our dental office. We strive to provide a fun and educational experience for your child while also maintaining the highest level of excellence in your child's care and treatment. Our ultimate goal is teaching good oral hygiene that will enable our patients to maintain beautiful smiles for a lifetime!

Please complete the detailed medical form. This information will allow us to provide your child with the safest comprehensive dental care possible. Please feel free to ask questions about an item that is not familiar.

Pediatric Patient Information

Patient's name: ______________________________ Nickname: ______________________________

Home address: ______________________________ City, State & Zip: ______________________________

Contact Phone Number: ____________________ (Cell, Home, Work) Preferred Contact: ____________________

Date of Birth: ____________Age: _______ Social Security #: __________________ ☐ Male ☐ Female

Who may we thank for referring you? ____

Legal Guardian Information

Mother's Information: ☐ Mother ☐ Step Mother ☐ Legal Guardian ☐ Grandmother

Name: ________________________ Date of Birth: _________ Social Security #: ___________________

Address: _________________________________ City, State & Zip: ______________________________

Preferred Phone Number: ____________________ (Cell, Home, Work) Email: ____________________________

Father's Information: ☐ Father ☐ Step Father ☐ Legal Guardian ☐ Grandfather

Name: ________________________ Date of Birth: _________ Social Security #: ________________

Address: _________________________________ City, State & Zip: ___________________________

Preferred Phone Number: ____________________ (Cell, Home, Work) Email: ___________________________

Dental Insurance Information

Primary Insurance: _______________________ Phone Number: _________________________________

Subscriber: _________________________ ID/SSN: _________________________ DOB: _____________

Employer: _________________________ Group Number: __________________________________

Secondary Insurance: _____________________ Phone Number: _________________________________

Subscriber: ___________________________ ID/SSN: _______________________ DOB: _____________

Employer: _________________________ Group Number: _________________________________

Emergency Contact Information

In case of an emergency where either the parent or legal guardian cannot be reached, please identify the following information for the next closest relative not living with the patient.

Name: _______________________________ Relationship to patient: ____

Address: ____ Phone: ___________________________________

Medical History

Please list the name and phone number of any physicians that are currently treating your child. When was your child's last medical check-up with his/her primary care physician?

____

Please list **all medications** patient is currently taking? ____

Please list **all allergies (food/medications)**? ____

Has your child ever had any of the following conditions?

Yes	No		Yes	No	
☐	☐	Sickle Cell Anemia or Trait	☐	☐	Measles, Mumps or Chicken Pox When? __________
☐	☐	Bleeding Disorders/ Hemophilia	☐	☐	Skin Disorder or Eczema
☐	☐	Blood Transfusion Date(s): ______________	☐	☐	Tonsillectomy or Adenoidectomy When? _________
☐	☐	Hypertension	☐	☐	Chronic Ear Infections / Otitis Media
☐	☐	Anemia	☐	☐	Tuberculosis or Positive Test Result When? _______
☐	☐	Heart Murmur (innocent or Pathologic)	☐	☐	Heart Condition ______________________________
☐	☐	Immunologic Disorder, HIV, AIDS, ARC	☐	☐	Hepatitis Type: __________ When? _____________
☐	☐	Hearing Impairment (right, left or both)	☐	☐	Eye Problems (right, left or both)
☐	☐	Rheumatic Fever	☐	☐	Thyroid Disorder
☐	☐	Bruises or Bleed Easily	☐	☐	Stomach or GI Disorder
☐	☐	Cystic Fibrosis	☐	☐	Cleft Lip/Palate (bilateral/unilateral)
☐	☐	Asthma or Lung Problems (Inhaler, Nebulizer)	☐	☐	Pneumonia When? ___________________________
☐	☐	Seasonal Allergies, Hay Fever, etc.	☐	☐	Diabetes Mellitus (NIDDM or IDDM _______x day)
☐	☐	Cancer, Malignancy, Leukemia, or Lymphoma	☐	☐	Appendectomy When? ________________________
☐	☐	Kidney Disease of Transplantation	☐	☐	Liver Disease or Transplantation
☐	☐	Urinary Tract Disorder	☐	☐	Chronic Constipation
☐	☐	Febrile Seizure, Fainting Spells	☐	☐	Congenital Birth Defects/Syndromes
☐	☐	ADD, ADHD or Hyperactivity	☐	☐	Emotional or Behavioral Problems
☐	☐	Learning Disability	☐	☐	Psychiatric Problems
☐	☐	Autism	☐	☐	Physical or Emotional Abuse
☐	☐	Neurological Disorder (Hydrocephaly, Microcephaly)	☐	☐	Delayed Development, MR approx. age child functions? _________________________________

Dental History

☐ Yes ☐ No Has your child ever been treated by a dentist? ______________ Date of last dental visit? _____________

☐ Yes ☐ No A Pediatric Dentist? If yes, whom?

____

☐ Yes ☐ No Has your child ever had dental x-rays? Date? ____

☐ Yes ☐ No Does tour child suck his/her thumb, finger, pacifier or blanket? ___________________________________

☐ Yes ☐ No Does your child brush his/her teeth? Do you assist? ________________ How often? _________________

☐ Yes ☐ No Does your child floss his/her teeth? Do you assist? _________________ How often? _________________

☐ Yes ☐ No Does your child snack between meals? ____

☐ Yes ☐ No Has your child been prescribed fluoride supplements? ____

How would you predict your child's behavior to be today? ☐ Cooperative ☐ Nervous ☐ Defiant ☐ Don't Know

What are your primary concerns regarding your child's oral health and/or reason for today's visit?

Has your child ever suffered from any of the following dental related problems?

Yes	No		Yes	No	
☐	☐	Bad breath/Halitosis	☐	☐	Popping or soreness of the jaws (right, left or both)
☐	☐	Bleeding Gums	☐	☐	Dental infection or abscess
☐	☐	Stained or Discolored teeth	☐	☐	Missing or extra teeth
☐	☐	Pain from teeth	☐	☐	Cold sores or fever blisters
☐	☐	Dry mouth	☐	☐	Previous injury or trauma to teeth, mouth or face
☐	☐	Orthodontics	☐	☐	Cavities If so please explain: ___________________________

NOTE: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patients Name Print | Print Parent/Legal Guardian Name | Signature Parent/Legal Guardian | Date

(Office use only): Print Name of Treating Dentist | *Signature of Treating Dentist | Date