The Greensboro Center for Pediatric Dentistry

Child's Full Name:_____Name child goes by:_____

□ M □ F Date of Birth:_____ Age:_____

Address:_____ City/State: _____ Zip:_____

Home Number: _____ Cell Phone Number_____

Please list any other siblings seen in this office:_____

Who may we thank for referring you to us? _____

Parent/LG Name_____ Relationship to Patient: _____

Primary E-mail:_____Primary Dental Insurance:_____

Physician/Phone#: _____

Did you have any complications during your pregnancy? _____

Is your child under the care of a physician for any illness? Yes__ No__ Is your child up to date on all current immunizations? Yes__ No__

Is your child allergic to any drugs or Latex products? Yes__ No__ If yes, please list_____

Is your child taking any medications? Please list_____

Has your child ever had any health concerns?_____

Anything else you would like to tell us about your child?_ _____

Feeding Practices:

Breast Fed	Yes_____ No_____ Till Age____
Bottle Fed	Yes_____ No_____ Till Age____
Sippy cup use	Yes_____ No_____
Sleeping w/ something other than water	Yes_____ No_____
>4-6oz juice/day	Yes_____ No_____
Soda use	Yes_____ No_____
Frequency of snacking >3 X/day	Yes_____ No_____

Oral Hygiene Practices:

Started cleaning teeth	Yes_____ No_____
Difficulty cleaning teeth	Yes_____ No_____
Started Flossing	Yes_____ No_____
Fluoride toothpaste	Yes_____ No_____

Fluoride Exposure:

Source of drinking water at home	City____ Well____ Bottled____
Child stays outside home during the day	Yes_____ No_____
Fluoride supplements prescribed	Yes_____ No_____

Oral Habits:

Finger/thumb/pacifier Yes_____ No_____ If yes, is anything associated with habit? Yes_____ No_____
(e.g. blanket, teddy bear, etc.)_____

Problems with teeth noted Yes_____ No_____

Injury Prevention:

History of dental trauma Yes_____ No_____

Family History of Dental Problems:_____

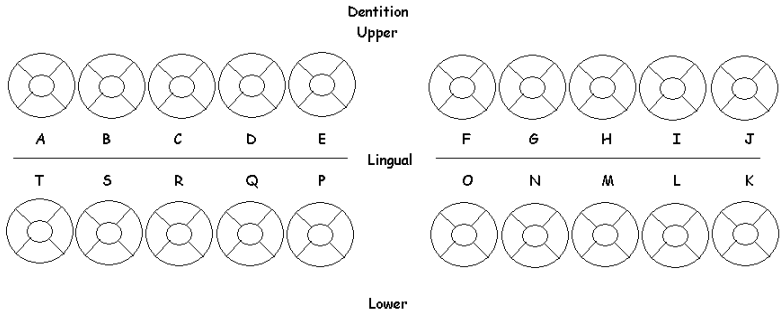
I give my consent for my child to have an oral exam and fluoride application if appropriate.

Parent/Guardian Signature:_____ Date_____

This visit is complimentary. If you have dental insurance please provide us with your information.

OFFICE USE ONLY

Clinical Examination:



Caries Risk: High____ Mod____ Low____

Soft Tissue Pathology: Yes_____ No_____

Enamel Defects: Yes_____ No_____

Plaque Present: Yes_____ No_____

Comments:_____

Procedure Performed:

Fluoride varnish applied Yes_____ No_____

Education Completed Yes_____ No_____

Recommendations:

1._____

2._____

3._____

Frankl Behavior Score: 1 2 3 4

Date of visit: ____ / ____ / _____ Child's Age: _____

Return to office: _____

Form completed by:_____