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GENERAL INFORMATION

Child's Name _____ Date of birth _____ Age _____ Male Female
Patient's Address _____ Home Phone _____

Mother's Name _____ Guardian Step Marital Status _____ DOB _____
Mother's Address (if different) _____ Home Phone (if different) _____

Mother's Employer _____ Bus. Phone _____
Business Address _____

Father's Name _____ Guardian Step Marital Status _____ DOB _____
Father's Address (if different) _____ Home Phone (if different) _____

Father's Employer _____ Bus. Phone _____
Business Address _____

In case of emergency and parent unavailable, call: Name _____ Phone _____
Whom may we thank for sending you to us? _____

Child's physician or pediatrician _____ If Kaiser, include Patient # _____

Dental Insurance Mother: Yes No Company _____ Group No _____

Dental Insurance Father: Yes No Company _____ Group No _____

Secondary Insurance: Yes No Company _____ Group No _____

MEDICAL HISTORY (These questions help us to treat and better understand your child.)

~ DOCTOR'S NOTES ~

- Is your child:
Under a physician's care for any medical problem Yes No
Up to date on immunizations Yes No
Taking Medicine Yes No If yes, what _____
Taking fluoride Yes No Your water is fluoridated Yes No
• Date of child's last dental care _____
• Has your child ever been hospitalized, had operations, or been seriously injured Yes No
• Does your child have or has your child ever had:
Heart Disease or Heart Murmur Yes No Seasonal Allergies Yes No
Fainting spells, convulsions, or epilepsy Yes No Kidney disease Yes No
Lung disease (TB, Asthma, or other) Yes No Diabetes Yes No
Liver disease (hepatitis, jaundice, or other) Yes No Blood disorder Yes No
Prolonged bleeding following injuries or surgery Yes No Cleft lip and / or palate Yes No
Physical Handicaps Yes No Frequent Headaches Yes No
Sore throats, tonsillitis, or ear aches Yes No Speech problems Yes No
Learning problems (ADD, Dyslexia, Hyperactivity) Yes No Emotional problems Yes No
• Is your child allergic to any food, medicine, or latex? Yes No
If so, please explain _____
• Does your child have any limitations regarding diet or activity Yes No
• Has your child had any physically or emotionally traumatic experience that you feel would be helpful for us to know about _____
• How would you describe your child
 Shy Frightened Strong-Willed Outgoing Other: _____
• Is there anything of importance in your child's medical or dental history that has not been asked _____
• Are there any siblings? If so, names are _____

Parent or Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT. I have received a copy of this office's Notice of Privacy Practices.
SIGNATURE _____ DATE _____



CARIES RISK ASSESSMENT

Child's Name _____ Date _____

Are there any current dental problems or concerns? _____

DIET & NUTRITION

Is your child now breastfed? [] Yes [] No Using a bottle? [] Yes [] No Using a sippy cup? [] Yes [] No

If yes, at what time(s) of the day or night? _____

What does the bottle or sippy cup contain? _____

Does your child often share feeding utensils or drinking glasses with others? [] Yes [] No

Does another caregiver supervise food choices? (For example, daycare, grandparent) [] Yes [] No

What beverage(s) does your child most often drink? (Check any that apply)

[] milk [] juice [] soda [] tap water [] bottled water [] bottled water with flouride [] other: _____

What snacks does your child most often eat? (Check any that apply)

[] candy [] chips [] cookies [] fruit [] raisins [] fruit roll-ups [] dried fruit

[] raw vegetables [] cheese [] crackers [] popcorn [] other: _____

HABITS Does your child

Use a pacifier? [] Yes [] No

Suck a [] thumb [] finger [] lip [] other object: _____ [] None

Grind his / her teeth at night? [] Yes [] No

Breathe through the mouth most of the time? [] Yes [] No

Have chronic irritation around the mouth? [] Yes [] No

ORAL PROBLEMS

Has your child had any oral injury? [] Yes [] No

If yes: What age was your child when the injury occurred? _____

Please describe the injury _____

Does your child now have any of the following?

Abscess (gum boil) [] Yes [] No Toothache [] Yes [] No Canker sore [] Yes [] No

Fever blister (cold sore) [] Yes [] No Bad breath [] Yes [] No

HISTORY OF DENTAL CARE

YES

NO

DON'T KNOW

Does your child have a cavity now? []

[]

[]

Do other family members get a lot of cavities? []

[]

[]

Has your child had cavities in the past? []

[]

[]

Has he/she had dental fillings? []

[]

[]

Was the treatment: [] easy [] difficult

Did you directly observe the treatment? []

[]

[]

Was some form of sedation used? []

[]

[]

If yes, please check what was used:

[] nitrous oxide [] oral sedation [] general anesthesia (put to sleep) [] don't know