

LINDA P. RAFFERTY, D.D.S.

Specialist in Pediatric Dentistry

2520 Douglas Blvd., Suite 130, Roseville CA 95661 (916)782-2278

www.RosevillePediatricDentists.com



GENERAL INFORMATION

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

Mother's Name Marital Status DOB
Mother's Address (if different) Soc. Sec. No.
Home Phone (if different) Cell Phone

Mother's Employer Bus. Phone
Email

Father's Name Marital Status DOB
Father's Address (if different) Soc. Sec. No.
Home Phone (if different) Cell Phone

Father's Employer Bus. Phone

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

DOCTOR'S NOTES

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

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

When does your child take this

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

If so, please explain:

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, ADHD, Hyperactivity) Yes No Sensory Issues 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



## CARRIES 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? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do other family members get a lot of cavities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had cavities in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she had dental fillings? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the treatment: <input type="checkbox"/> easy <input type="checkbox"/> difficult			
Did you directly observe the treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was some form of sedation used? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please check what was used:

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