MILLHOPPER PEDIATRIC DENTISTRY, PL

PATIENT INFORMATION

Patient Name_____DOB_____ Sex_____ Chart #_____

Dental	Yes	No
• Has your child ever been seen by a dentist?	___	___
• Will your child be a cooperative dental patient?	___	___
• Does your child suck fingers or thumb or have similar habits?	___	___
• Does your child participate in sports activities?	___	___
• Is your community water supply fluoridated?	___	___
• Have you ever given your child vitamins or tablets with fluoride?	___	___
• Does your child brush regularly?	___	___
• Does your child floss regularly?	___	___
Health		
• Is your child presently being treated by a physician?	___	___
• Is your child immunization up-to-date?	___	___
• Does your child have any drug allergies?	___	___
• Is your child currently taking any medication?	___	___
• Has your child ever been a patient in a hospital?	___	___
• Has your child ever been a patient in an emergency room?	___	___

Place a check if your child has (had) problems with the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart	___	___	Liver	___	___	Asthma	___	___	Allergies	___	___
Heart murmur	___	___	Hepatitis	___	___	Diabetes	___	___	Speech	___	___
Rheumatic Fever	___	___	Kidney	___	___	Epilepsy	___	___	Emotions	___	___
Bleeding	___	___	Muscles	___	___	Bones	___	___	Other	___	___

If any of the above answers are yes, please explain:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____Relationship_____Date_____

********** ***For Office Use Only*** **********

Radiographic Record

Date	BW	Pan	PA	Occl
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Height/Weight Record

Date	Ht(in)	Wt(#)	Date	Ht(in)	Wt(#)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____