Welcome to Fox Point Dental!

The information on this form will help us give you more reliable and successful treatment.
Please fill out both sides carefully and completely. Thank you.

Patient Name:_____ Birthdate: _____
Parent/Guardian Name:_____ Residence Phone:_____
Parent Email:_____
Residence Address:_____ City: _____ State: _____ Zip:_____
Social Security Number:_____

If someone other than the patient is responsible for payment, please fill out the following section.

Person Responsible For Payment: _____Date of Birth:_____
Relation To Patient: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Business Phone: _____
Business Address: _____ City: _____ State: _____ Zip:_____

If there is any form of dental coverage, please complete the following:

Name of Carrier:_____
Employer or Union: _____ Group Number: _____
Employee Name:_____
Employee Social Security Number: _____
Policy Holder's Date of Birth: _____
Has patient had care under this plan? _____ When? _____
Is patient covered under another plan? ❑ YES ❑ NO

Person not at your address to be contacted in case of an emergency.
Name:_____
Address: _____ City: _____State:____ Zip:_____Phone:_____

Treatment Authorization
I agree to diagnostic procedures and dental treatments as found necessary and desirable for the patient named above. This includes the use of study models, radiographs (x-rays), local anesthetic, and relaxing agents.
I agree to be financially responsible for treatment rendered.

_____ _____
Patient, Parent, or Legal Guardian Date

Who may we thank for referring you to our office?_____

Pediatric Health History

Patient Name: _____ Date:_____

Name of Physician or Clinic:_____
Last visit to their medical provider?_____
Any SLP, OT, Myofunctional Therapy, IBCLC, or other medical specialist in the past? ❑ YES ❑ NO
If yes, please explain: _____

Does your child have, or have they ever had, any of the following? Please check.

❑ Abnormal Blood Pressure
❑ Allergies
❑ Anemia or Blood Disorder
❑ Asthma
❑ Bleeding Problems
❑ COVID-19
❑ Cancer
❑ Diabetes
❑ Epilepsy
❑ Heart Disease or surgery
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ Liver or Kidney Disease
❑ Lung Disease
❑ Rheumatic Fever
❑ Sinus Problems
❑ Sleep Apnea
❑ Stroke
❑ Thyroid Disease
❑ Tongue or Lip Tie
❑ Tonsil/Adenoid Removal
❑ Tuberculosis
❑ Tumor History
❑ Ulcers
❑ Upper Airway Resistance
❑ Other:_____

Do your child have a medical problem? ❑ YES ❑ NO If yes, please explain: _____
Have they been hospitalized in the past five years? ❑ YES ❑ NO If yes, please explain: _____
Are they taking any prescribed medications? ❑ YES ❑ NO If yes, please list below:
Taking: _____
Are they taking any supplements or vitamins? ❑ YES ❑ NO If yes, please list below:
Taking: _____
Have they ever had a bad reaction or allergy to medication? ❑ YES ❑ NO If yes, please explain:_____
Have they had problems with: ❑ Codeine ❑ Penicillin ❑ Aspirin ❑ Local Anesthetic (Novocaine) ❑ Other
Do they have any limitations in their activities? ❑ YES ❑ NO If yes, please explain:_____

I attest that the medical and dental history provided are true.

Parent or guardian Name: _____ Relationship: _____

Parent or guardian Signature: _____ Date: _____

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Medical History Reviewed: _____Date: _____

Pediatric Dental History

Patient Name: _____ Date:_____

How can we help you? What is your immediate dental concern? What are your treatment goals?

_____

Date of Last Dental Visit:_____ Date of last full mouth x-rays:_____
Previous Dentist:_____ City: _____ State: _____

Is your child presently having dental pain? ❑ YES ❑ NO If yes, where?_____
Have you noted any unusual changes in or around your child's mouth? ❑ YES ❑ NO If yes, where?_____
Are you pleased with the appearance of your child's teeth? ❑ YES ❑ NO If yes, please explain:_____
Has your child lost any teeth? ❑ YES ❑ NO If yes, from what cause?_____
Has your child had any orthodontic treatment? ❑ YES ❑ NO If yes, how old were they?_____
Was your child breastfed? ❑ YES ❑ NO For how long:_____
Was your child bottlefed? ❑ YES ❑ NO For how long:_____
Any difficulty with breastfeeding or bottlefeeding? ❑ YES ❑ NO If yes, please explain:_____
Do you help your child with brushing or flossing? ❑ YES ❑ NO
How often are they brushing? _____ How often are they flossing? _____
Does your child avoid brushing or chewing in any part of their mouth? ❑ YES ❑ NO
Do you have any speech concerns with your child? ❑ YES ❑ NO If yes, explain: _____
Does your child have feeding issues (for example, "picky eater")? ❑ YES ❑ NO If yes, explain:_____
Was your child premature? ❑ YES ❑ NO If yes, explain:_____
Any history of cleft lip, cleft palate, tongue or lip ties? ❑ YES ❑ NO
Any family history of cleft lip, cleft palate, tongue or lip ties? ❑ YES ❑ NO
Any history of reflux or digestive issues? ❑ YES ❑ NO
Does your child sleep restlessly (for example, messed up covers)? ❑ YES ❑ NO If yes, explain:_____
Does your child sleep noisily (for example, snoring or loud breathing)? ❑ YES ❑ NO If yes, explain:_____
Does your child sleep with an open mouth (mouth breathe)? ❑ YES ❑ NO
Does your child sit regularly with an open mouth (mouth breathe)? ❑ YES ❑ NO
Does your child clench or grind their teeth, day or night? ❑ YES ❑ NO
Does your child have flattened or shortened teeth? ❑ YES ❑ NO
Does your child have a history of bedwetting? ❑ YES ❑ NO If yes, how frequently?_____
Does your child have dry lips? ❑ YES ❑ NO
Does your child typically sleep through the night? ❑ YES ❑ NO If no, please explain:_____
Is there anything we should know to give your child better, more comfortable care? ❑ YES ❑ NO
If yes, please explain:_____

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Dental History Reviewed: _____Date: _____