

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY

Pediatric Dentistry

Biographical Data

(Filled out by parent or guardian)		Date:	Patient Number:
▼▼▼ Please print ▼▼▼			
Last Name:		First Name:	Middle Name:
Nickname:		Date of Birth:	Age:
Home Address:			City:
State:	Zip:	Telephone/home:	
Father's Name:		Age:	Marital Status: S M W D
Place of Business:		Work Phone:	
Business Address:			
Mother's Name:		Age:	Marital Status: S M W D
Place of Business:		Work Phone:	
Business Address:			
Legal Guardian (if other than parent):			
Place of Business:		Work Phone:	
Business address:			
Pet, Hobbies of patient:			
Brothers/Sisters: (name and ages)			
Person responsible for this account:			
Is your child covered by: <input type="checkbox"/> Social Agency Agency's name:			
<input type="checkbox"/> Dental Insurance Number:			
Referred by:			
Reason for seeking care:			

PLEASE COMPLETE THE BACK PORTION OF THIS APPLICATION ►►►

Medical History

1.	Does your child have any health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, explain:	
2.	Did your child have a history of health problems at birth or during initial years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, explain:	
3.	Is your child taking medication or drugs at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please list:	
4.	Has your child ever had any unfavorable reactions to foods, drugs, or medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please list:	
5.	Has your child ever been hospitalized or injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Reason: _____	Date: _____
6.	Does your child have any limitations to sports activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, explain:	
7.	Has your child had any history of the following?	
	<input type="checkbox"/> Allergies	<input type="checkbox"/> Breathing problems
	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Heart trouble
	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Kidney/liver problems
	<input type="checkbox"/> Mental/emotional problems	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Other:	<input type="checkbox"/> Growth problems
	Comments:	
8.	Date of last medical examination:	
9.	Name of pediatrician or family physician:	
10.	Does your child have problems in:	
	<input type="checkbox"/> concentration	<input type="checkbox"/> learning
	<input type="checkbox"/> cooperating	<input type="checkbox"/> understanding
11.	Do you think your child will be a cooperative patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is there additional medical information we should know?	<input type="checkbox"/> Yes <input type="checkbox"/> No

DENTAL HISTORY

1.	Is this your child's first visit to a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	If no, give date of last examination: Dentist's name:	
3.	Has your child ever had any of the following? Please check:	
	<input type="checkbox"/> abscesses (gum boils)	<input type="checkbox"/> toothaches
	<input type="checkbox"/> cold sores (fever blisters)	<input type="checkbox"/> injury to front teeth
	<input type="checkbox"/> frequent sore throats	<input type="checkbox"/> bleeding gums
		<input type="checkbox"/> bad breath
		<input type="checkbox"/> stained teeth
4.	Does (or did) your child have habits which might affect oral health? If yes, check:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> clenching or grinding teeth	<input type="checkbox"/> mouth breathing
	<input type="checkbox"/> finger or thumb habits	<input type="checkbox"/> other:
5.	Does your child have a speech problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Does your child take fluoride at school?	<input type="checkbox"/> Yes <input type="checkbox"/> No