31067 US Highway 19 N.
Palm Harbor, FL 34684

harp PEDIATRIC DENTISTRY

727-333-9333

Patient Information

Title: ________ Nickname: ________
Last, First: ________
Address: ________
____
City, State, Zip: ________
Email: ________
Health Care Guardian Name: ________
Health Care Guardian Phone #: ________

Birth Date: ________
Marital Status: ________
Cell #: ________
Home #: ________
Emergency Contact: ________
Student: ________
School Name: ________
Referral Type: ________

Age: ________
Sex: ________
Work #: ________
Driver License #: ________
Emergency Phone #: ________
SSN: ________

Person responsible/guarantor for paying bill

Title: ________ Nickname: ________
Last, First: ________
Address: ________
____
City, State, Zip: ________
Email: ________

Birth Date: ________
Marital Status: ________
Cell #: ________
Home #: ________
SSN: ________

Age: ________
Sex: ________
Work #: ________
Drive License #: ________

Primary Dental Insurance

Group No/Name: ________
Insurance Name: ________
Phone #: ________
Employer Name: ________
Subscriber Last, First: ________
Subscriber Address: ________
City, State, Zip: ________
Relationship to Patient:
Subscriber ID: ________ Birth Date: ________

Secondary Dental Insurance

Group No/Name: ________
Insurance Name: ________
Phone #: ________
Employer Name: ________
Subscriber Last, First: ________
Subscriber Address: ________
City, State, Zip: ________
Relationship to Patient: ________
Subscriber ID: ________ Birth Date: ________
:

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Patient Medical Information
Please circle YES or NO

Allergic To

Y N Any known Allergies
Y N Aspirin
Y N Penicillin
Y N Codeine
Y N Erythromycin
Y N Amoxicillin
Y N Hydrocodone
Y N Latex Rubber
Y N Epinephrine
Y N Local Anesthetics
Y N Metals
Y N Red or Blue Dye
Y N Sulfa Drugs
Y N Seasonal Allergies
Y N Other Allergies

Circle, if applicable

Y N Abnormal/Excessive Bleeding
Y N Acid Reflux/GERD
Y N ADD/ADHD
Y N AIDS/HIV Infection
Y N Alcohol/Drug Abuse
Y N Angina/Chest Pain
Y N Anemia
Y N Antibiotic Premedication
Y N Anxiety
Y N Artificial Joints/Replacement
Y N Arthritis
Y N Asthma
Y N Autism
Y N Autoimmune Disease
Y N Blood Clotting Problems
Y N Blood Disease
Y N Brain Stents
Y N Brain Surgery
Y N Breathing/Respiratory Issues
Y N Cancer
Y N Cardiac Pacemaker
Y N Cerebral Palsy
Y N Chemotherapy
Y N Cleft Palate
Y N Congenital Heart Defect
Y N Delayed Development
Y N Dementia/Alzheimers
Y N Diabetes Type 1
Y N Diabeted Type 2
Y N Downs Syndrome
Y N Eating Disorders
Y N Epilepsy/Seizures
Y N Failure to Thrive
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N G-Tube
Y N Gag Reflex
Y N Glaucoma
Y N Hearing Impairment
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Heart Stens
Y N Heart Valve Replacement
Y N Hepatitis
Y N Prior Hepatitis
Y N High Blood Pressure
Y N Kidney Disease
Y N Leukemia
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mental Health Problems
Y N Mitral Valve Prolapse
Y N MTHFR Deficiency
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Rheumatic Heart Disease
Y N Sensory Disorders
Y N Sexually Transmitted Disease
Y N Sinus Problems
Y N Sjogren Syndrome
Y N Stomach Problems
Y N Stomach Ulsers
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Tumors/Growths
Y N Vision Impairment
Y N See's a Specialist Physician

Additional Comments: ______________________________

____

____

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Dental Questionnaire

Name of the person filling out this form: ____________________
Relationship to the patient: ____________________

Name of the patient's previous dentist and office phone number: ____________________
Date of the patient's last cleaning and exam: ____________________
Date of the patient's last full series of Panoramic x-rays: ____________________
Date of the patient's last cavity detection (bitewing) x-rays: ____________________
What is the purpose for the patient's visit today? ____________________
Does the patient regularly use dental floss? ____________________
How many times a day for the patient brush? ____________________
Does the patient's gums bleed while brushing or flossing? Y N
Are the patients teeth sensitive to hot, cold or sweets? Y N
Does food catch between the patient's teeth? Y N
Does the patient have unpleasant taste or odor in their teeth/mouth? Y N
Does the patient notice popping, clicking or soreness of the jaws or joints? Y N
Does the patient clench or grind their teeth? Y N
Does the patient ever have difficulty in opening their mouth widely? Y N
Has the patient ever had orthodontic treatment? If yes, when? Y N
What, if anything, would the patient like to improve about their smile? Y N

CHILDREN ONLY

Is the patient's water fluoridated? Y N
Does the patient take fluoride supplements? Y N
Does the patient have speech problems? Y N
Circle if the patient has or has previously had any of these habits?
None Known *Thumb/Finger Sucking* *Pacifier* *Bottle* *Tongue Thrust* *Nail Biting* *Chewing Inanimate Objects* *Other*

ADULTS ONLY

Does the patient have, or have they ever been told, they have Periodontal Disease? Y N
Has the patient has any periodontal therapy such as deep cleanings or surgery? Y N
If yes, what & when? ____________________
Does the patient have any loose teeth Y N
Does the patient have missing teeth they would like replaced? Y N
Does the patient wear dentures or partials? If yes, are they happy with them? Y N

ADDITIONAL COMMENTS: ____________________

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Medical Questionnaire

Name of the person filling out this form: ______________________
Relationship to the patient: ______________________

Patient's physician name: ______________________
Phone number: ______________________
Date of the patient's last physical exam: ______________________
Preferred pharmacy's name and number: ______________________
Is the patient currently under the care of a Physician? ______________________
If yes, what is the condition being treated? ______________________
Specialist Physician names and phone numbers, if applicable: ______________________
Has the patient had any serious illness, operation or been hospitalized in the past 5 years? Explain Y N ______________________
Please list all medications and over the counter supplements the patient is currently taking: ______________________
Does the patient use alcoholic beverages? If yes, how often? ______________________
Does the patient smoke, dip or chew tobacco? If yes, how much per day? ______________________
Ever taken bisphosphonates? Y N
(*Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reciast*)

WOMEN ONLY

Are you pregnant? Y N
If yes, what is your due date? ______________________
Are you currently nursing? Y N
Are you on hormone replacement therapy? Y N
Are you on birth control pills/fertility drugs? Y N

ADDITIONAL COMMENTS

Any disease, allergy, conditions or problem not listed? Please list: ______________________
DOCTOR'S COMMENTS:______________________

By signing below, I certify that all of the above information is true to the best of my knowledge.
NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfactions. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of these forms.

______________________ ______________________
Parent/Guardian's Signature Date