Candice Sullivan, DDS.

Pediatric Dental Specialist

Dentistry for Toddlers, Adolescents, and the Physically-challenged

Date _____

Child's Full Name_____ Nickname _____

Sex _____ Age _____ Date of Birth _____ Height _____ Weight _____

Child's Social Security # _____

Mother's Information:

Name _____ Social Security # _____ Date of Birth _____

Work Phone # _____ Cell Phone # _____ Email Address _____

Father's Information:

Name _____ Social Security # _____ Date of Birth _____

Work Phone # _____ Cell Phone # _____ Email Address _____

Insurance Information:

Name of Insurance Carrier: _____ Social Security # _____

Employer _____ Date of Birth _____

Child's Information:

Mailing address _____ Home Phone # _____

Reason for today's visit _____

Whom may we thank for referring you to our office? _____ Phone # _____

Pediatrician Name _____ Phone # _____ Date of last visit _____

Person responsible for child's account _____

Person to contact in case of emergency _____ Phone # _____

Turn over to complete →

Child's Medical History

Please answer YES or NO. If yes, explain.

Is your child presently under the care of a physician? _____

Is your child allergic to any food or medicine? What? _____

Was your child premature? If so, how may weeks? _____

Is your child currently taking any medication? _____

Has any member of the family had a negative reaction with general anesthetic? _____

Has your child had a history of? (Please check all that apply)

- ▫ Scoliosis
- ▫ Stomach Ulcers
- ▫ Heart Trouble/ Murmur
- ▫ Hepatitis or Jaundice
- ▫ Respiratory Problems
- ▫ Pain in jaw muscles
- ▫ Arthritis
- ▫ Painful back teeth
- ▫ Fainting spells/Dizziness
- ▫ Brain Injury
- ▫ Asthma or Hay fever
- ▫ Seizures/Epilepsy
- ▫ Frequent earaches
- ▫ Popping jaw sounds
- ▫ High blood pressure
- ▫ Kidney/Liver problems
- ▫ Diabetes
- ▫ Bleeding Disorders
- ▫ Developmental Delay

▫ Other (please describe in full detail) _____

★**If you have any additional concerns or information about your child, please let us know.**

Child's Dental History

Is today your child's first dental visit…… ▫ YES ▫ NO

Previous Dentist _____ Date of last visit _____

- ➢ Has your child ever experienced an unfavorable reaction to dental treatment? _____
- ➢ How do you think your child will react toward the dentist? _____
- ➢ How often does your child brush? _____ Is it supervised? _____ By whom? _____
- ➢ Is dental floss used? _____ Any trauma or injury to their teeth? _____
- ➢ Does your child receive fluoride in: _____ Vitamins _____ Tablets/Drops _____Water
- ➢ Any history of: ▫ Nursing bottle habits
  - ▫ Thumb or finger-sucking
  - ▫ Recent dental pain
  - ▫ Mouth breathing
  - ▫ Pacifier use

- ☐ Lip sucking
- ☐ Frequent headaches
- ☐ Grinding or clenching

} If you answered yes to these, please fill out the enclosed TMJ Questionnaire.

The permission of a parent or guardian is necessary for dental treatment of a minor. I hereby give Dr. Candice Sullivan permission to use such measures deemed necessary in her professional judgment to render the best treatment for my child. I also give permission for photographs to be taken for diagnosis, treatment planning and teaching purposes. If I have any questions regarding treatment for my child, I do understand that I may consult the doctor.

Signature _____ Relationship to the child _____ Date _____

Payment is expected for services rendered at the time of the first visit. Thank you very much.