Bippo's Place FOR SMILES
Great Fun . . . Great Smiles

Kids Dental Zone

PATIENTS INFORMATION

Name _____ Nickname_____ ❑Male ❑Female SS# _____

Pediatrician _____ Dr. Phone _____ Date of Birth _____ Age _____

Name(s) and Age(s) of siblings in our practice_____

Referred to us by _____ Language _____

Race_____ School _____

CONFIRMING INFORMATION

Which is the best contact number? ❑home:_____ ❑cell:_____

Can we call you at work? ❑yes ❑no   If yes, work number _____ Name_____

E mail Address to confirm appointment _____

PARENT OR LEGAL GUARDIAN INFORMATION   Do you have dental insurance? ❑yes ❑no

Person responsible for payment _____ Social Security # _____

Father or legal guardian_____   Mother or legal guardian_____

Address _____   Address _____

City _____   City _____

Zip _____ Phone _____   Zip _____ Phone _____

Employed by _____   Employed by _____

Marital Status ❑Married ❑Widowed ❑Separated ❑Divorced ❑Single

PATIENT MEDICAL HISTORY

Is your child adopted?   Yes No   Foster child?   Yes No
Is your child in poor health?   Yes No   If yes, explain _____
Is your child under the care of a physician?   Yes No   If yes, explain _____
Has your child ever had surgery   Yes No   If yes, explain _____
Has your child ever had complications
following dental treatment?   Yes No   If yes, explain _____
Is surgery contemplated?   Yes No   If yes, explain _____
Does your child have any health problems
that need further clarification?   Yes No   If yes, explain _____
List all medications your child is taking _____
Last Dental Cleaning_____

Does your child have/ever had any of the following? Please check those that apply

- ❑ AIDS/HIV Positive
- ❑ Asthma
- ❑ ADHD/ADD
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Blood Transfusion
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Autistic
- ❑ Cerebral Palsy
- ❑ Developmentally Delayed

- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Tumors
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Learning Disabilities
- ❑ VP Shunt
- ❑ Special Needs

- ❑ Nervous Disorders
- ❑ Physically Impaired
- ❑ Pregnancy
- ❑ Due date:_____
- ❑ Depression
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Ulcers
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Acid Reflux
- ❑ Sickle Cell Trait
- ❑ Sickle Cell Anemia
- ❑ Spina Bifida

- ❑ Food Allergy_____
- ❑ Seasonal Allergies
- ❑ Red Dye Allergy
- ❑ Latex Allergy
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ Other Drug Allergy
- ❑ Substance Abuse
- ❑ Nicotine Use
- ❑ Alcohol Use

  OTHER:

- ❑ _____
- ❑ _____

DENTAL HISTORY

	YES	NO
Is this the child's first visit to a dentist?	_____	_____
Do you have fluoridated water at home?	_____	_____
Have there been any injuries to teeth?	_____	_____
If yes, please explain _____		
Has child had any unfavorable dental experience?	_____	_____
Does child suck thumb or finger?	_____	_____
Does child have any other habits?	_____	_____
Does child still take bottle or breastfeed?	_____	_____
Does parent help with oral hygiene?	_____	_____
Does child have a TOOTHACHE?	_____	_____

Signature _____ Relationship _____ Date _____