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# PEDIATRIC DENTAL ASSOCIATES, P.C.

## PERSONAL QUESTIONNAIRE FOR NEW PATIENTS

(PLEASE PRINT IN INK)

Please complete all sections of this form. This pertinent information will assist us in providing the best quality care for your child. If the space is inadequate, use "Remarks" section on back page. Thank you for your cooperation. (Note: Questions are on ALL FOUR SIDES.)

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Employer (Father) \_\_\_\_\_ Employer (Mother) \_\_\_\_\_  
Work Address \_\_\_\_\_ Work Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Legal Guardian (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

Any responsible adult (non-parent or legal guardian) whom you authorize to escort the child to and from a dental appointment and act as your agent during the appointment.

Child's School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address of Physician \_\_\_\_\_  
Date of Last Physical Exam \_\_\_\_\_  
Child's Pets & Hobbies \_\_\_\_\_  
Participates in sports/wears mouthguard \_\_\_\_\_

1. Purpose of today's visit: \_\_\_\_\_

Has your child experienced or is experiencing any of the following?

_____ Toothache	_____ Broken tooth	_____ Thumb habit
_____ Cavities	_____ Bleeding gums	_____ Other habits
_____ Lost fillings	_____ Bad breath	_____ Crooked teeth
_____ Headaches	_____ Sore spots in mouth	_____ Jaw pain/Limitations
_____ Other		

2. Past dental history of child: Circle either YES or NO.

Is this the first visit to a dentist? YES NO

If your child has been to a dentist before:

Does your child go regularly to a dentist? YES NO

Date of last visit \_\_\_\_\_

Were X-rays taken? YES NO

Name of Previous Dentist \_\_\_\_\_

Address and Phone of Dentist \_\_\_\_\_



Has your child had accidents involving teeth? If yes, explain? _____	YES	NO
Is there flouride in your water supply? If no, has your water been tested for flouride?	YES	NO
Does your child take a fluoride supplement? If yes, what/dose _____ Who prescribed _____ When prescribed _____	YES	NO
Does your child brush/floss his/her teeth? How often? _____	YES	NO
Do you help your child brush/floss?	YES	NO

3. Birth History

What was your child's birth weight? _____		
Were there any problems during pregnancy? If yes, what? _____	YES	NO
Did mother take any medication during pregnancy? If yes, what? _____	YES	NO
Were there any problems with the delivery? If yes, what? _____	YES	NO
Was your child born premature?	YES	NO
Did your child exhibit any birth defects? If yes, what? _____	YES	NO
Did your child require any special medical care in the first few days of life? If yes, what? _____	YES	NO
Did your child go home with mother from the hospital?	YES	NO
Is your child adopted? (For evaluation of hereditary factors.)	YES	NO
Any other pertinent information _____		

4. Growth and Development:

Have there ever been concerns about your child's physical development? If yes, what? _____	YES	NO
Did your child ever repeatedly sleep/nap while nursing or drinking a bottle? If yes, until what age? _____	YES	NO
Does your child:		
Suck fingers or thumb?	YES	NO
Use a pacifier?	YES	NO
Lip bite or suck?	YES	NO
Breath through their mouth?	YES	NO
Clench/Grind teeth? When? _____	YES	NO
Follow instructions?	YES	NO
Have any speech concerns?	YES	NO
Receive any special assistance in school? If yes, what? _____	YES	NO
Are there any concerns that you would like us to know about? If yes, what? _____	YES	NO

5. General Health:

Does your child have regular medical checkups?	YES	NO
Are immunizations up-to-date?	YES	NO
Is your child being treated by a physician now? If yes, for what reason? _____	YES	NO
Does your child have any chronic or long-term medical conditions? If yes, what? _____	YES	NO
Is your child taking any medication? (Prescription/non-prescription drugs) If yes, what? _____ Dose _____ How often? _____ Why? _____ Who prescribed _____ Address and phone of Doctor _____	YES	NO

Is your child taking any herbal supplements? YES NO  
 If yes, what? \_\_\_\_\_ Why? \_\_\_\_\_  
 Has your child had any unfavorable reaction to medications, including antibiotics and local anesthetics? YES NO  
 If yes, specify? \_\_\_\_\_  
 Does your child bruise easily? YES NO  
 Does your child bleed excessively when cut? YES NO  
 Has your child ever been hospitalized? YES NO  
 When? \_\_\_\_\_ Where? \_\_\_\_\_  
 Why? \_\_\_\_\_  
 Has your child sustained any significant injuries? YES NO  
 If yes, what? \_\_\_\_\_

Does your child have, or has ever had? (please give age)

Measles _____	Frequent headaches _____
Mumps _____	Bleeding problems _____
Chicken pox _____	Blood disorders _____
Whooping cough _____	Heart disease _____
Rheumatic fever _____	Heart murmur _____
Asthma _____	Liver disease _____
Diabetes _____	Seizures _____
Digestive disorders _____	Frequent colds _____
Eye problems _____	Ear infections _____
Hepatitis _____	Cancer/tumors _____
HIV _____	Frequent infections _____
Tuberculosis _____	Sinus problems _____
Breathing problems _____	Cyclic vomiting _____
Adrenal gland disorders _____	ADHD _____
Hearing problems _____	Allergies (seasonal/latex, etc.) _____
Other _____	Describe _____

Are there any other significant problems not previously mentioned? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician Specialists Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

6. Family History:

Is mother living? YES NO  
 Is father living? YES NO  
 Are parents living together? YES NO  
 Names and ages of brothers \_\_\_\_\_  
 Names and ages of sisters \_\_\_\_\_  
 Does mother see dentist regularly? YES NO  
 Are mother's teeth and gums in good health? YES NO  
 Does mother have missing teeth? YES NO  
 Did mother have orthodontic treatment? YES NO  
 Does mother have dental anxiety? YES NO  
 Does father see dentist regularly? YES NO  
 Are father's teeth and gums in good health? YES NO  
 Does father have missing teeth? YES NO  
 Did father have orthodontic treatment? YES NO  
 Does father have dental anxiety? YES NO  
 Name and address of parent's dentist \_\_\_\_\_  
 \_\_\_\_\_  
 How did you happen to call our office? \_\_\_\_\_

REMARKS:

**Consent for Examination and Treatment**

I, the undersigned, have completed the above questionnaire to the best of my knowledge. Any information that I feel may not be complete will be discussed with the doctors and/or staff.

I authorize the doctors and their dental staff to perform an oral examination, a dental prophylaxis (cleaning), and, if appropriate, topical fluoride application. Dental radiographs (x-rays) may be taken as necessary (in accordance with the guidelines established by the American Dental Association) to complete the diagnosis of my child's oral condition. If dental treatment becomes necessary, I authorize the performance of necessary treatment, medication, and therapy that is indicated in connection with dental care of the above minor patient and authorize the doctors to choose and employ such techniques and assistance as deemed fit during the treatment. I understand that I will have the right to be provided with answers to questions which may arise during the course of my child's diagnosis and treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

Furthermore, I will be responsible for financial obligations incurred on this child for dental treatment.

Name (Printed) \_\_\_\_\_

Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_