Laura McCormack DDS, MSD – Growing Smiles Pediatric Dentistry - 62 Corporate Park, Suite 135, Irvine CA 92606 - (949)252-9950

Patient First Name:_____ Last Name:_____ DOB:_____

Dental Information

	Y	N	
Is/Was your child bottle-fed?	☐	☐	If yes, until what age?_____
Is/Was your child breast-fed?	☐	☐	If yes, until what age?_____
Does your child like to snack during the day?	☐	☐	If yes, what kind/how often?_____
Does your child drink juices/sweetened drinks?	☐	☐	If yes, what kind/how often?_____
Has your child ever had injuries to his teeth, mouth, head or jaws?	☐	☐	If yes, describe?_____
Does your child brush daily?	☐	☐	
Does an adult assist with brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with flossing?	☐	☐	
Has the primary caregiver had cavities in the last year?	☐	☐	If yes, describe?_____

Does your child have any of the following mouth habits?

☐Finger Sucking ☐Pacifier ☐Lip Sucking ☐Teeth Grinding
☐Thumb Sucking ☐Tongue Thrusting ☐Mouth Breather

Does your child receive fluoride in any of the following forms?

☐Vitamin ☐Water Supply ☐Tablets/drops ☐Toothpaste ☐Rinse/Gel

Medical Information

Child's Pediatrician:_____ Address:_____ Phone:_____

Date of Last Physical:_____

	Y	N
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Is your child being treated for any condition presently?	☐	☐
If so, explain:_____		
Is your child taking medications or drugs?	☐	☐
If so, explain:_____		
Has your child ever been hospitalized or had surgery?	☐	☐
If so, explain:_____		
Does your child have any allergies or reactions to any medications?	☐	☐
If so, explain:_____		

Does your child have any allergies to the following: ☐**pollen** ☐**food/food dyes** ☐**dust** ☐**latex** ☐**other**_____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Chronic Headaches	☐	☐	Hemophilia
☐	☐	Allergies to Medication	☐	☐	Chronic Ear Infections	☐	☐	Hepatitis or Liver Disease
☐	☐	Anemia	☐	☐	Cleft Lip/ Palate	☐	☐	Hyperactivity
☐	☐	Asthma/Lung problems	☐	☐	Convulsions/Seizures	☐	☐	Kidney Disease
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Leukemia
☐	☐	Behavior/Language Problems	☐	☐	Endocrine System	☐	☐	Mental/Emotional Disturbances
☐	☐	Bladder Conditions	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency
☐	☐	Blood Transfusions	☐	☐	Eye Problem	☐	☐	Oral ulcers
☐	☐	Birth Defects	☐	☐	Excessive Bleeding Problem	☐	☐	Orthopedic Problem
☐	☐	Bone or Joint Problems	☐	☐	Excessive Gagging	☐	☐	Premature Birth
☐	☐	Brain Injury	☐	☐	Fainting or Dizziness	☐	☐	Rheumatic Fever
☐	☐	Bruising Easily	☐	☐	Frequent Infections	☐	☐	Sickle Cell Anemia
☐	☐	Cancer or Malignancies	☐	☐	Growth & Development	☐	☐	Significant Injury
☐	☐	Cerebral Palsy	☐	☐	Hearing/Speech Problem	☐	☐	Syndrome_____
☐	☐	Child Abuse	☐	☐	Heart Problems	☐	☐	Other_____
☐	☐	Chronic Adenoid/Tonsil Infection						

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information:

_____

Parent/Guardian Signature:_____Date:_____

DDS Signature:_____