



New Patient Information and Health History

Today's Date _____

Section 1: Tell Us About Your Child

Child's Full Name _____

Preferred Name _____

Male Female SS# _____

Child's Birthdate ____/____/____ Age _____

School _____

Home Address _____

City _____ State _____ Zip _____

Section 2: Parent/Guardian Contact Information

Name _____

Parent Stepparent Legal Guardian

Best Contact Number _____

Alternative Number _____

Email _____

What is your appointment confirmation preference (please check all that apply)

Text Phone Email

Section 3: Responsible Person For Payment

Name _____

Parent Stepparent Legal Guardian

Phone # _____

Phone # _____

Home Address _____

City _____ State _____ Zip _____

Birthdate ____/____/____ SSN _____

Employer _____

Insurance Co. Name _____

Insurance Phone _____

Insurance Identification # _____

Secondary Dental Insurance (if applicable)

Insurance Co. Name _____

Insurance Phone _____

Insurance Identification # _____

Additional Information _____

Section 4: How Did You Hear About Us?

- Family/Friend
- Social Media
- Reviews
- Google/Search
- Advertisement
- Healthstart
- Insurance
- Physician
- Dawson

Referral Source _____

Section 5: Accompanying Your Child

A parent or legal guardian must be present during appointments.

Please list any person(s), other than legal parents/guardians, who are authorized to accompany your child to any routine dental visits

Name _____

Relation _____

Name _____

Relation _____

Authorized person(s) must present ID upon arrival

None; only legal parents/guardians may accompany

Section 7: Dental History

Please tell us the reason for today's visit.

- First visit to dentist
- Change of dental care
- Emergency
- Other

If not the first visit, when did they see a dentist prior?

Date _____

Dentist _____

Address _____

Were X-Rays taken? Yes No

Have there been any injuries to the teeth, face, or mouth?
 Yes No If yes, please explain

Has your child had any pain or tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does your child have any of the following habits/concerns?

- Thumb/Finger Sucking
- Lip Sucking/Biting
- Nursing/Bottle Habits
- Tooth Grinding
- Other _____
- Mouth Breathing
- Nail Biting
- Pacifier Use
- Snoring

Childs Name _____

Section 7: Dental History cont.

Has your child ever had a serious or difficult problem associated with dental work or a dental visit? Yes No
If Yes, please explain _____

Does your child brush his/her teeth daily? Yes No
Does your child floss his/her teeth daily? Yes No

Section 8: Health History

- | | |
|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Disability/Special Needs |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease/Murmur |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Hospital Stays |
| <input type="checkbox"/> Bone/Muscular Disorders | <input type="checkbox"/> Immune Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney/Liver Condition |
| <input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Convulsion/Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> None of the above |

Please provide us with details regarding any medical conditions your child may have.

Medical conditions _____

List all medications your child is taking None

List all allergies (drugs, latex, etc.) None

Any other concerns _____

Childs Primary Care Physician _____

Office Address _____

City _____ State _____ Zip _____

Phone Number _____

Section 9: Are You On Social Media?

If your child participates in our contests, awards, fun signs, celebrations and or photo booths we'd love to share photos with our friends and family! So that our friends can like and share in your child's experiences at our office, do we have your permission to use your child's picture on our social media pages? Photos may be displayed on Facebook, Instagram, Website and in the office on display boards. Yes No

Section 10: HIPAA

The privacy of your health information is very important to us and our practice follows all HIPAA regulations. Notice of our HIPAA Privacy Practices with complete details have been made available to you and a copy of our HIPAA guidelines is available review or you may request a hard copy from us. Please initial below to acknowledge that you have read and understand our HIPAA Privacy Practice Notice. I have carefully read this office's Notice of Privacy Practices. I understand that I am entitled to receive a paper copy of this office's Notice of Privacy Practice. **Initial** _____

Section 11: Broken Appointment Policy

Realizing that we all have busy schedules and that unforeseen situations may occur, we wish to make you aware of the scheduling guidelines for our dental practice. If you find that you are unable to keep your scheduled appointment, we require 2 full business days' notice in order to prevent a failed appointment fee of \$50.00. Please understand this is not something we desire to do. I understand the above information and agree to its contents. **Initial** _____

Section 12: Authorization To Treat

Our office is committed to meeting and exceeding the standards of infection control mandated by OSHA the CDC, and the ADA. I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff at Dental Buddies of Vero Beach to perform the necessary dental services my child may need based on our treatment plan.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____



Dear Parent,

As part of the comprehensive services provided at Dental Buddies and Dental Partners we are asking all patients to include a Healthy Start Sleep Disordered Breathing Questionnaire with their Health History. This questionnaire will give us an overall evaluation of your child's sleeping patterns and patterns of their daily living. Studies show that an estimated 9 out of 10 children suffer from sleep disordered breathing, interrupted sleep, that leads to numerous health concerns. Our goal is to assist our patients through diagnosis and a treatment plan that if instituted will provide long-term health benefits. We look forward to reviewing this evaluation with you. Thank you.

Patient: _____
Completed by: _____

Today's date: _____
DOB: _____ Age: _____
Relation to patient: _____

Sleep Disordered Breathing Questionnaire For Children

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dated at the first appointment with us and the follow-up score column should be evaluated and dated, after 3 months of treatment, by the same person who completed the initial assessment.

Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5

Initial Score	Follow-Up Score		Initial Score	Follow-Up Score	
1. _____	_____	Snoring of any kind	16. _____	_____	Falls asleep watching TV
2. _____	_____	Snores infrequently (1 night per week)	17. _____	_____	Wakes up at night
3. _____	_____	Snores often (2-4 nights per week)	18. _____	_____	Attention deficit
4. _____	_____	Snores habitually (5-7 nights per week)	19. _____	_____	Restless sleep
5. _____	_____	Has labored, difficult, loud breathing at night	20. _____	_____	Grinds teeth
6. _____	_____	Has interrupted snoring, breathing stops for more than 4 or more seconds	21. _____	_____	Frequent throat infections
7. _____	_____	Has stoppage of breathing more than 2 times in an hour	22. _____	_____	Frequent ear infections
8. _____	_____	Hyperactive	23. _____	_____	Feels sleepy and /or irritable during the day
9. _____	_____	Mouth breathes during the day	24. _____	_____	Difficult time listening and often interrupts
10. _____	_____	Mouth breathes while sleeping	25. _____	_____	Fidgets with hands and does not sit quietly (please check all that apply)
11. _____	_____	Frequent headaches in the morning			<input type="checkbox"/> Muscular tics
12. _____	_____	Allergy symptoms (please check all that apply)			<input type="checkbox"/> Restless (wiggles) legs
		<input type="checkbox"/> Asthma <input type="checkbox"/> Eczema	26. _____	_____	Wets bed
		<input type="checkbox"/> Nasal congestion	27. _____	_____	Blush color at night or during the day
		Other _____	28. _____	_____	Nightmares and/or night terrors
13. _____	_____	Excessive sweating	29. _____	_____	Exhibits any of the following (please check all that apply)
14. _____	_____	Talks in sleep			<input type="checkbox"/> Rarely smiles <input type="checkbox"/> Feels sad
15. _____	_____	Poor ability in school (please check all that apply)			<input type="checkbox"/> Feels depressed
		<input type="checkbox"/> Math <input type="checkbox"/> Science	30. _____	_____	Speech Problems
		<input type="checkbox"/> Spelling <input type="checkbox"/> Writing			If scored greater than 0 for Speech Problems please continue to the 2nd page of the Healthy Start Questionnaire.
		<input type="checkbox"/> Reading <input type="checkbox"/> Other			

If you answered that you feel your child has a speech delay or problem on the first page of this questionnaire please complete the following questions to the best of your ability.

We look forward to reviewing this evaluation with you. Thank you.

Patient: _____
Completed by: _____

Today's date: _____
DOB: _____ Age: _____
Relation to patient: _____

Speech Questionnaire Further Speech Assessment For Children

Not Present: 0		Very Mild: 1		Mild: 2		Moderate: 3		Pronounced: 4		Severe: 5	
Initial Score	Follow-Up Score					Initial Score	Follow-Up Score				
1. _____	_____	Do you or others have difficulty understanding your child's speech?				9. _____	_____	Seems winded when increases volume?			
2. _____	_____	Is it difficult to understand the child over the phone?				10. _____	_____	Any difficulty in swallowing?			
3. _____	_____	Does the child use grunts or screams more than words?				11. _____	_____	Do you think your child has a stutter?			
4. _____	_____	Lisp?				12. _____	_____	Any family history of a stutter? Y/N			
5. _____	_____	Hoarseness?				13. _____	_____	Tourette's syndrome?			
6. _____	_____	Nasal speech?				14. _____	_____	Family history of a speech or language disorder?			
7. _____	_____	Has frustration when attempting to speak?						Any speech therapy?			
8. _____	_____	Often uses words with only 1 or 2 syllables?						If so for how long? _____			

Specific Articulate Questions

Not Present: 0		Very Mild: 1		Mild: 2		Moderate: 3		Pronounced: 4		Severe: 5	
Does your child present with any of the following speech patterns?											
1. _____	_____	hap for hat, kif for kiss, fum for thumb, or bav for bath Child replaces a t, d, n, s, z, th, with a p, b, m, w, f, or v				6. _____	_____	ship for chip, shoo shoo for choo choo Child replaces a ch or a j sound with a sh, v, f, th, or s			
2. _____	_____	wabbit for rabbit, yewo for yellow, weg for leg, pway for play, wun for run Child replaces an r with a w or an L with a w or a y				7. _____	_____	pasghetti for spaghetti, efelant fot elephant, baksit for basket Child changes position of a sound within a word			
3. _____	_____	tock for sock, dumb for jump, pan for fan, bat for fat Child replaces a s, f, v, z, th, j, or h with a consonant such as p, b, t, d, k, g				8. _____	_____	Stuh-reet for street, fuh-wong for frog, buh-lue for blue, puh-lease for please Child inserts uh into words			
4. _____	_____	Sum for thum, muhzer for mother Child replaces a p, b, m, w, th, f, or v with a t, d, s, z, n, or L				9. _____	_____	Doat for goat, tuhtie for cookie, tuo for cup, hud for hug Child replaces a k or a g with a t or d			
5. _____	_____	gog for dog, cop for top, boke for for boat, key for tea Child replaces a t or a d with k or g				10. _____	_____	Sue for shoe, sip for ship, Mezza for measure Child replaces a sh with a s			