MILESTONES
PEDIATRIC DENTISTRY

PATIENT HISTORY

Child's name first_____middle_____last_____ Gender: M / F

Prefers to be called_____ Birthdate _____/_____/_____

Address: street_____city_____

state_____ zip_____

Home Phone _____ Mother's Cell _____Father's Cell _____

Family's primary email address _____

Future appointments may be confirmed via email. Please inform the staff if you do not wish to receive these emails.

Whom may we thank for referral? Internet search _____ Insurance _____ Yellow pages_____ Advertisement _____

_____ Relative/Friend_____ Pediatrician_____

Dentist_____ Other_____

PARENT/GUARDIAN INFORMATION

Mother's name_____

Date of birth _____

SSN _____---_____---_____

Address (if different from above):

_____

_____

_____

Occupation_____

Father's name_____

Date of birth _____

SSN _____---_____---_____

Address (if different from above):

_____

_____

_____

Occupation_____

DENTAL INSURANCE INFOMATION

PRIMARY dental insurance plan name _____ Insurance phone # _____

Subscriber's name _____ Relationship to patient _____

Subscriber's SSN or member/policy ID # _____ Member DOB _____

Group # _____ Subscriber's Employer_____

(IF APPLICABLE) Secondary dental insurance plan name _____ Insurance phone # _____

Subscriber's name _____ Relationship to patient _____

Subscriber's SSN or member/policy ID # _____ Member DOB _____

Group # _____ Subscriber's Employer_____

MILESTONES PEDIATRIC DENTISTRY, PC
Dr. Carolyn Lubrano | 696 Newport Avenue, Attleboro MA 02703 | (508) 399-8200
info@MilestonesPediatricDentistry.com | www.MilestonesPediatricDentistry.com

DENTAL HISTORY

Is this your child's first visit to a dentist? Y / N If no, former dentist _____

Date of last dental visit_____ Reason for visit? _____

How many times a day is your child brushing? zero | 1x | 2x | 3x+

Does he/she floss? Y / N

Does he/she take fluoride in any of these forms? Tablets/Drops | Toothpaste | Rinse/Gel | Bottled H20 | Other

Have any current complaint of dental pain? Y / N If yes, please explain: _____

_____

Does your child have a history of:

___Thumb/finger sucking ___Pacifier ___Bottle feeding ___Breastfeeding ___Sippy cup___Speech issues ___Bleeding/Sore gums ___Mouth breathing ___Bad breath ___Grinding/clenching ___Abscess/infection ___Nail biting ___

Other _____

MEDICAL HISTORY

Pediatrician _____ Phone_____

Address/town _____

Date of last physical _____

Please list the medications your child is currently taking: _____

Has your child ever been hospitalized or had surgery? Y / N

If yes, please explain: _____

Does your child have allergies to ___Penicillin/Amoxicillin ___Sulfa ___ Latex ___ Other (Please specify all known allergies including food and environmental allergies):_____

Has your child had any of the following? Please circle all that apply:

AIDS/HIV | Cerebal Palsy | Jaundice (severe) | Seizures | ADHD/ADD | Convulsions/Epilepsy | Kidney disease) | Sinus problems | Anemia | Diabetes | Learning disablity | Speech delay | Asthma | Ear infections (chronic) _Liver disease _ Stomach/GI _ Autism/PDD/Spectrum _Genetric disorder _ Measles problems _Birth defect _Head injury _ Mononucleosis _Tuberculosis _Bleeding disorder _Hearing disability _ Mumps _Tumor _Blood transfusion _Heart mumur _Psychiatric care _Vision problems _Bone disorder _Heart problems _ Radiation therapy _Bronchitis _Hepatitis _Respiratory issues _Cancer _High blood pressure _Rheumatic fever Other: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. If there are any changes in child's information and/or health status, I will inform the doctor as soon as reasonably possible and without fail. I understand that this information will remain confidential.

Signature of Parent/Guardian: _____Date _____

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