Harrisburg Pediatric Dentistry

4079 Harris Square Drive I Harrisburg, NC 28075 I 704-377-3688

Today's Date ____/____/________

Patient's Name ____ DOB ____/____/________

Address ____ Age ____________

____

Phone: Home (____) ______________ Work (____) ______________ Cell (____) ______________

Email Address ____

Any changes to insurance since last visit? ☐ Yes ☐ No

If yes, please list change: Carrier ______________________ Subscriber ______________________

Subscriber's Date of Birth ____/____/________ ID# ______________________

Please describe any changes in your child's medical history since your last visit: ______________________

____

We are aware that some insurance companies only cover topical fluoride treatments once a year. However, the Academy of Pediatric Dentistry recommends this treatment be administered 1 time every 6 months, along with a child's cleaning appointment. If your insurance company fails to cover this procedures, you will be responsible for payment. Please indicate if you prefer this treatment today. ☐ Yes ☐ No

I, being the parent/guardian of the above minor patient, do hereby authorize the performance of routine dental services for this patient. This includes dental examination of hard and soft tissue, cleaning, fluoride (if applicable), check and repair sealants (if applicable), and necessary radiographs. I agree to be responsible for all changes for dental services and materials not paid by my dental plan. ☐ Yes ☐ No

Has your child ever had any of the following medical problems? (Circle appropriate response)

Y N Allergies
Y N Anemia or Blood Disorders
Y N Asthma or Hay Fever Please indicate type and current medications: ______________
____
Y N Autism
Y N Bladder/Kidney Problems
Y N Bleeding/Bruises Easily
Y N Blood Transfusion
Y N Blood Pressure, High/Low
Y N Bronchitis
Y N Cancer/Chemotherapy
Y N Cerebral Palsy
Y N Congenital Heart Defect If yes, are Premed needed? Y N
Y N Convulsions/Seizures, Fainting or Epilepsy
Y N Childhood Illnesses
Y N Diabetes
Y N Down Syndrome
Y N Handicap, Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hepatitis, Liver Problems
Y N HIV/AIDS
Y N Learning Disorder
Y N Psychological, Emotional Problems
Y N Rheumatic Fever
Y N Speech Disorder
Y N Tuberculosis

List any drugs or medications child is currently taking: ______________________

Are child's immunizations current? ☐ Yes ☐ No Please explain: ______________________

Does your child have any special needs or special circumstances? (i.e., Autism, Cerebral Palsy, Down Syndrome)

____

Signature of Parent/Guardian ________________________________ Date ____/____/____

Relationship to Patient ________________________________

Form 102 Rev 7/18

Name ______________________________ Date ______________

Oral Hygiene ______________________ Cooperation ☐1 ☐2 ☐3 ☐4

XRays Completed ______________ Caries Risk Assessment ☐Low ☐Moderate ☐High

BRUSHING ______________ **FLOSSING** ______________ **DRINKS** ______________

FACIAL PROFILE

☐ Straight ☐ Convex ☐ Concave

TMJWNL

MOLAR RELATIONSHIP

Permanent	R	L	**Primary**	R	L
End-to-End	☐	☐	Terminal Plane	☐	☐
Class I	☐	☐	Straight	☐	☐
Class II	☐	☐	Mes. Step	☐	☐
Class III	☐	☐	Dist. Step	☐	☐

CANINE RELATIONSHIP R L

Class ____ ____

INCISOR RELATIONSHIP

Overjet ________ mm

Overbite ________ %

Openbite ________

MIDLINE: ☐ Normal ☐ Deviates

XRays ______________

	R	L	
Maxilla	☐	☐	mm ________
Mandible	☐	☐	mm ________
Mandibular Shift ☐ No ☐ Yes	☐	☐	mm ________

ARCH LENGTH (general impression)

Maxilla	Mandible
☐ Adequate	☐ Adequate
☐ Inadequate	☐ Inadequate

ANALYSIS RECOMMENDED

☐ Yes ☐ No ☐ In Treatment

☐ Future ______________

Related Findings: (Describe Abnormalities)

Eruption Sequence	WNL	☐ Abnormal
Ankylosed Teeth	☐ No	☐ Yes
Crossbite	☐ No	☐ Yes
Oral Habits	☐ No	☐ Yes:

Polished ______________

Supernumerary Teeth	☐ No	☐ Yes
Congenitally Missing Teeth	☐ No	☐ Yes
Ectopic Eruption	☐ No	☐ Yes

Intraoral______ Buccal Mucosa WNL______

Abnormal ______

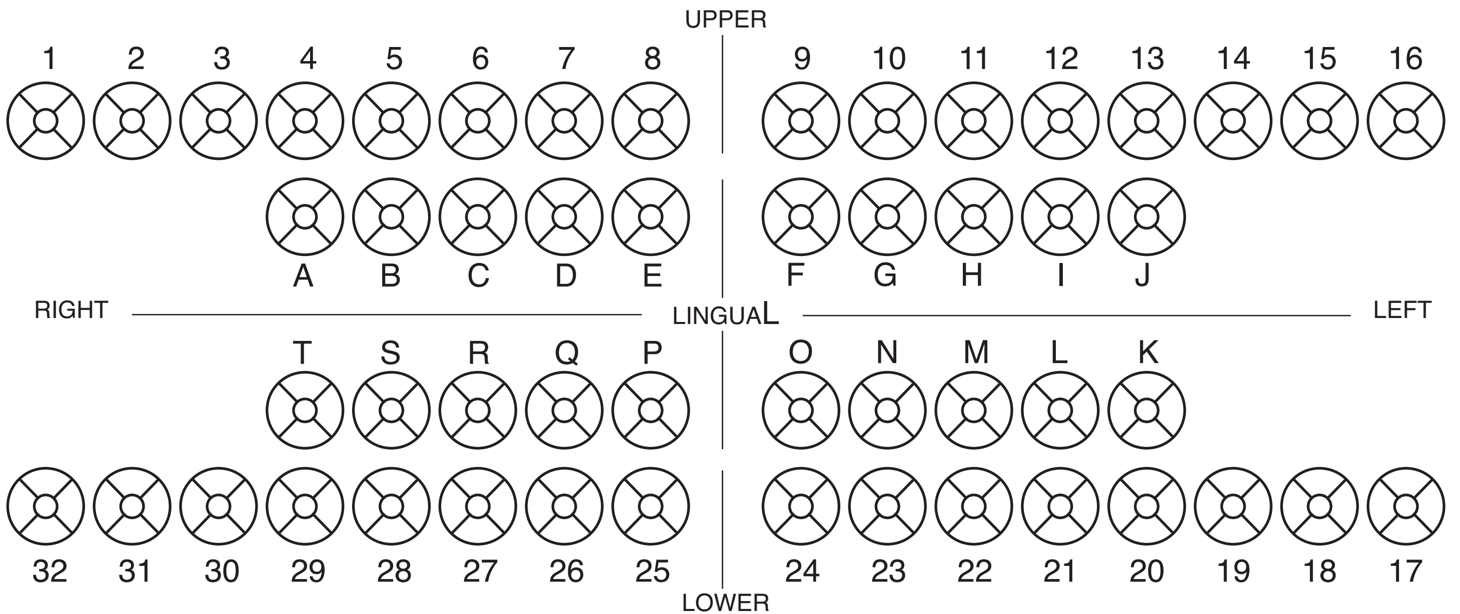
Frenum	☐ Normal	☐ Heavy
Tongue	WNL	☐ Abnormal
Palate	WNL	☐ Abnormal
Gingiva	WNL	☐ Abnormal

Other Abnormalities ______________

____

TRAUMA	☐ No	☐ Yes
ENAMEL DEFECTS	☐ No	☐ Yes
DISCOLORATION	☐ No	☐ Yes:
FLOUROSIS	☐ No	☐ Yes
DIASTEMA	☐ No	☐ Yes

Scaled ______________



NOTES: ______________________________

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