

# CATHERINE JUDD DDS

## PEDIATRIC DENTISTRY

MEDICAL PLAZA 400 \* 3713 W. FIFTEENTH STREET \* SUITE 404 \* PLANO, TEXAS 75075 \* 972-596-5203

### PERSONAL INFORMATION

Date \_\_\_\_\_ Parent's E-Mail \_\_\_\_\_

Patient's Name \_\_\_\_\_ Name used \_\_\_\_\_ Age \_\_\_\_\_  
First Middle Last

Name of child's favorite pet/hobby/playmate \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street City Zip

How long at this address? \_\_\_\_\_ If less than 5 years, list previous address below:

Address \_\_\_\_\_  
Street City Zip

Father's First/Middle/Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's First/Middle/Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

With whom does patient live? \_\_\_\_\_

### DENTAL HISTORY

REASON FOR VISIT \_\_\_\_\_

Family Dentist \_\_\_\_\_ Referred by \_\_\_\_\_

1. Does/did your child take a bottle to bed at night? Yes/No Age Discontinued \_\_\_\_\_

2. Does your child use fluoride other than toothpaste at home? Yes/No What? \_\_\_\_\_

3. Does your child suck his thumb/finger/pacifier? (please circle) Yes/No

4. Does your child have a toothache? Yes/No

5. Is this your child's first visit to the dentist? Yes/No

If no, date of last dental examination \_\_\_\_\_ Name of dentist \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

6. Has your child experienced any unfavorable reaction from any medical or dental care? Please explain:

### ORAL HYGIENE

I always/sometimes/never supervise my child's brushing. Tooth brushing is completed \_\_\_\_\_ times a day.

Do you ever notice that your child eats or swallows toothpaste? Yes/No Name of child's tooth paste \_\_\_\_\_

Name of child's fluoride supplement (if applicable) \_\_\_\_\_

