CATHERINE JUDD DDS

PEDIATRIC DENTISTRY

2004 VENTURA DRIVE / SUITE 250 / PLANO, TEXAS 75093 / 972-596-5203

PERSONAL INFORMATION

Date _____ **PARENT'S EMAIL**_____

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 INSURANCE INFORMATION

Dental Insurance Company _____ Telephone Number_____

Claims Mailing Address _____ State _____ Zip _____

Subscriber Name _____ Relationship to Patient _____

ID Number/ Subscriber Social Security Number _____Date of Birth _____

Subscriber's Address (if different than patient) _____

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:

_____

-PLEASE CONTINUE ON BACK-

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) _____

FAMILY DENTAL HISTORY

Mom/Dad has history of frequent dental treatment? _____

Mom/Dad has weak teeth? _____

Mom/Dad has cavities as an adult? _____

Mom/Dad has congenitally missing teeth? _____

HEALTH HISTORY

Child's Physician _____ Phone _____

Date of last medical exam _____

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD:

_____ Anemia	_____ Cleft Lip / Palate	_____ Hearing Loss	_____ Mental Retardation
_____ Attention Deficit Disorder	_____ Convulsions / Seizures	_____ Heart Disease	_____ Nutritional Deficiency
_____ Allergy	_____ Diabetes	_____ Hemophilia	_____ Orthopedic Problem
_____ Asthma	_____ Emotional Disturbance	_____ Hepatitis—Type _____	_____ Rheumatic Fever
_____ Autism	_____ Epilepsy	_____ Heart Murmur	_____ Sickel Cell Anemia
_____ Brain Injury	_____ Eye Problems	_____ Hyperactivity	_____ Spina Bifida
_____ Cancer	_____ Excessive Bleeding Problem	_____ Jaundice	_____ Syndrome
_____ Cerebral Palsey	_____ Fainting	_____ Leukemia	_____ Other

_____ Child is in good health / None of the above

Explain any items checked above:

_____

1. Has your child **ever been hospitalized**? Yes/No _____
2. Is your child up to date with immunizations? Yes/No _____
3. Is your child **allergic to any medications**? Yes/No _____
4. Is your **child taking any current medications**? Yes/ No _____
   _____
   _____
   _____
5. Is your child **allergic to latex**? Yes/No
6. Have you ever been told that your **child needs premedication for a heart condition before dental treatment**? Yes/No If **Yes**, Explain:

_____
_____
_____

_____ _____ _____

Signature of person completing form **Relationship to patient** **Date**