Patient's Registration and History

Welcome to our practice!
To provide the best and safest comprehensive dental care for your child, we are thanking you in advance for completing our detailed medical history form.
Please print in blue or black ink.

Mary E. Tierney DDS, MS
Allison McMahon, DDS
Diplomates, American Board of Pediatric Dentistry

Child's Name: _____ **Preferred Name:**_____

Birthdate: _____ **Age:** _____ **Gender:** Male Female

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____

Please check YES (Y) or NO (N) as it applies to your child:

Y	N		Y	N		Y	N		Y	N	
□	□	ADD/ADDHD	□	□	Brain Injury	□	□	Epilepsy/Seizures	□	□	MRSA
□	□	Adopted	□	□	Bruises Easily	□	□	Eye Conditions	□	□	MSPI
□	□	AIDS/HIV	□	□	Cerebral Palsy	□	□	Fainting or Dizziness	□	□	Pregnancy (patient)
□	□	Allergy to Augmentin	□	□	Chemical Dependence	□	□	Hearing Impairment	□	□	Premature Birth
□	□	Allergy to Latex	□	□	Chemo/Radiation	□	□	Heart Disease/Condition	□	□	Psychiatric Care
□	□	Allergy to Peanuts	□	□	Chicken Pox	□	□	Heart Murmur	□	□	Sickle Cell Disease
□	□	Allergy to Omnicef/Ceph	□	□	Child Abuse			□ Innocent Heart	□	□	Sickle Cell Trait
□	□	Allergy to Pen/Amox	□	□	Cleft Palate/Lip			□ Needs SBE/Antibiotic	□	□	Speech Impairment
□	□	Allergy to Sulfa meds	□	□	Cold/Canker Sores	□	□	Hemophilia	□	□	Thyroid Disease
□	□	Allergies - seasonal	□	□	Depression	□	□	Hepatitis	□	□	Tonsillitis
□	□	Anemia	□	□	Developmental Delay	□	□	High Blood Pressure	□	□	Tuberculosis
□	□	Asthma/Reactive Airway			□ Motor	□	□	Injury - front teeth	□	□	Tumor, Cancer
□	□	Autism / Aspergers			□ Speech	□	□	Juvenile Rheumatoid Arthritis	□	□	Wheelchair
□	□	Behavioral Problems			□ Cognitive	□	□	Kidney Disease	□	□	Other:
□	□	Birth Defect	□	□	Diabetes	□	□	Liver Disease			_____
□	□	Blood Transfusion	□	□	Down Syndrome	□	□	Lung Disease			
□	□	Bone/Joint Problems	□	□	Earaches/Ear infections	□	□	Metal Implant/Pins/Rods			

Child's Medical Doctor: _____ **Phone:** _____ **Date of last exam:** _____

Is your child presently under the care of a physician or specialist for any reason?
□ YES □ NO Explain: _____
Doctor Name: _____ Phone: _____

Is your child taking any medications? Supplements? Or Vitamins?
□ YES □ NO List: _____

Does your child have any allergies to medicines, latex, foods, or metals not listed above?
□ YES □ NO List:_____

Are antibiotics necessary prior to dental work because of a heart murmur, defect, prosthesis, shunt, or any other medical reason(s)?
□ YES □ NO Explain: _____

Has your child been hospitalized, sedated, or had surgery?
□ YES □ NO Explain: _____

Has any member of the family, including your child, had a problem with sedation or general anesthesia?
□ YES □ NO Explain: _____
Are your child's immunizations up to date? □ YES □ NO

Is there any other health information that should be known?
□ YES □ NO Explain: _____

Dental History

Is this your child's first dental visit? □ YES □ NO
Previous Dentist: _____
Date of Last Exam: _____ Date of Last X-Rays: _____

How often does your child brush? _____ Is tooth brushing supervised? □ YES □ NO
Is dental floss used? □ YES □ NO

Does your child receive any of the following (check all that apply):

□ Fluoride in vitamins
_____ mg/day
□ Filtered tap water
□ Bottled water
□ Fluoridated tap water
□ Fluoride tablets/drops
_____ mg/day
□ Vitamins
□ chewable
□ gummy
□ liquid

Please indicate if your child has any of the following mouth habits (check all that apply):

□ Currently Breastfeeding
□ Bottle Feeding
□ Cheek Biting
□ Teeth Grinding/clinching
□ Thumb or finger sucking
□ Pacifier
□ Nail biting
□ Sippy Cup
□ Gagging easily
□ Mouth breathing
□ Snoring

Please estimate your child's daily exposure to:

Water:	_____ cups	Sports drinks:	_____ cups	Candy:	_____ cups	What is your child's favorite snack?
Milk:	_____ cups	Vitamin Water:	_____ cups	Fruit pouches:	_____ cups	_____
Soda:	_____ cups	Cookies:	_____ cups	Fruit snacks::	_____ cups	
Juice:	_____ cups	Crackers:	_____ cups	Dried fruits:	_____ cups	

Has your child suffered any injuries to your child's teeth or jaws?
□ YES □ NO Explain: _____

Has your child experienced any unfavorable reaction from previous dental or medical care?
□ YES □ NO Explain: _____

Has your child had recent dental pain or a specific dental problem that needs special attention?
□ YES □ NO Explain: _____

Does your child wear a mouth guard for sports? □ YES □ NO
Is there anyone in the family with a history or missing teeth? □ YES □ NO **Extra teeth:** □ YES □ NO
Do you have any questions prior to your child's visit today? □ YES □ NO

Consent

The permission of a parent or guardian is necessary for dental treatment of a minor.

As parent or guardian of the above patient, I authorize and request the performance of routine dental services and diagnostic records (including digital x-rays) for my child by Dr. Tierney, Dr. McMahon and their staff, as may be designated. If I accept a proposed treatment plan, I authorize Dr. Tierney, Dr. McMahon and their staff to use any anesthetics considered medically necessary or advisable (local anesthetic and/or nitrous oxide) along with patient management techniques that are reasonable, necessary, and advisable for the comfort and well-being of my child. I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition. I agree to inform Dr. Tierney, Dr. McMahon and their staff of any changes in the medical history. This authorization is valid until revoked in writing.

Signature: _____ Relation to child: _____ Date:: _____

Because referrals are important to us, who may we thank for referring you to our office?

□ Dentist/Orthodontist/Doctor: _____
□ Friend: _____
□ Google
□ Yelp
□ Facebook
□ Other: _____