

Children's Landing Pediatric Dentistry  
3855 West 7800 South Suite 200  
West Jordan, Utah 84088

**Patient Information**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Male / Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Parent's Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

**Tell us about your Child's Dental History**

Why did you bring your child to the dentist today? \_\_\_\_\_

Is this your child's first dental visit? Yes No Name of previous dentist: \_\_\_\_\_ Last visit date \_\_\_\_\_

How do you think your child will behave today? (Check all that may apply)

\_\_\_\_ friendly \_\_\_\_ happy \_\_\_\_ anxious \_\_\_\_ timid \_\_\_\_ afraid \_\_\_\_ resistant \_\_\_\_ combative

Has your child ever has a serious/difficult problem associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No Is your child taking fluoride supplements? Yes No

Does your child brush his/her teeth daily? Yes No Floss daily? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Are you happy with the appearance of your child's teeth? Yes No Explain if no \_\_\_\_\_

Does your child have any of the following habits?

Y N Lip Sucking/Biting Y N Nail Biting Y N Nursing/Bottle Habits Y N Thumb/Finger Sucking

**Tell us about your Child's Medical History**

Has your child had a history or difficulty with any of the following? If yes to any, please describe below.

Y N Abnormal Bleeding	Y N Diabetes	Y N Kidney/Liver Problems
Y N Any Blood Disease or Anemia	Y N Eye, Ear, Nose, Throat Problems	Y N Mental or Learning Delay
Y N Allergies to any drugs (list below)	Y N Gag Reflex	Y N Other Heart Ailment
Y N Asthma	Y N Handicaps/Disabilities	Y N Premature Birth
Y N Brain Injury	Y N Hearing Impairment	Y N Rheumatic Fever
Y N Cancer or Malignancies	Y N Heart Murmur	Y N Speech Disorder
Y N Cerebral Palsy	Y N Hemophilia	Y N Tuberculosis (TB)
Y N Congenital Heart Defect	Y N Hepatitis	Y N Tumors or Growths
Y N Convulsions/Epilepsy	Y N HIV/AIDS	Other, explain below

**If Heart Condition present, does your child require an antibiotic premed prior to having certain procedures done? Yes / No**

Name of child's physician \_\_\_\_\_ Phone #: \_\_\_\_\_

Is your child under doctor's care now? Yes No For what reason? \_\_\_\_\_

Please list all drugs or medications your child is currently taking: \_\_\_\_\_

Has your child had any serious medical problems? \_\_\_\_\_

Has your child ever been hospitalized and/or had operations? Yes No Reason: \_\_\_\_\_

Please list all drugs your child is allergic to: \_\_\_\_\_

**If you answered yes to any questions above, please give any additional information necessary.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_