Grover Dental Pediatrics

Dentistry for Children

3906 Tampa Rd., Suite C
Oldsmar, FL 34677
(813) 814-2933

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New Port Richey, FL 34685
(727) 375-0833

Raj Grover, D.M.D.

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Full Name _____ Nickname _____ Age _____

Sex _____ Race _____ Date of Birth _____ Social Security # _____

Patient's Address _____ Home Phone _____
Street City State Zip

School _____

Father's Full Name _____ Social Security # _____

His Address _____ Phone _____
Street City State Zip

Date of Birth _____

Where Employed? _____ Phone _____

Mother's Full Name _____ Social Security # _____

Her Address _____ Phone _____
Street City State Zip

Date of Birth _____

Where Employed? _____ Phone _____

Phone Numbers for confirmation of appointment _____

With whom does patient live _____

Other children in family - names and ages _____

Dental Insurance? yes ____ no ____ Company _____ Policy Number _____

Company _____ Policy Number _____

Medicaid? yes ____ no ____ Number _____ Other funds _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office _____
(Doctor) or (Parent) or (Patient)

Address, if known _____
Street City State Zip

(OVER)

HEALTH HISTORY

Is your child taking vitamins or flourides? ☐ Yes ☐ No ☐ Don't Know Brand or type: _____

Do you have flouride in your water system? ☐ Yes ☐ No ☐ Don't Know Source of drinking water: _____ (City, Well, etc.)

Is your child in good health? ☐ Yes ☐ No ☐ Don't Know

Does your child have regular medical examinations? ☐ Yes ☐ No ☐ Don't Know Date of last exam: _____

Is your child up to date with immunizations? ☐ Yes ☐ No ☐ Don't Know

Is this your child's first visit to the dentist? ☐ Yes ☐ No ☐ Don't Know

Is your child a thumb/finger sucker? ☐ Yes ☐ No ☐ Don't Know

Does your child use a pacifier? ☐ Yes ☐ No ☐ Don't Know

If your child was bottle fed, at what age was it discontinued? _____

How often are the child's teeth brushed each day? _____ By whom? _____

Check any of the following that may pertain to your child:

☐ Rheumatic fever	☐ Liver problem	☐ Epilepsy	☐ Mental disorder	☐ Seizures
☐ Heart condition	☐ Kidney problem	☐ Hepatitis	☐ Emotional disorder	☐ Pneumonia
☐ Speech disorder	☐ Asthma	☐ Diabetes	☐ Sickle Cell Anemia	☐ Heart murmur
☐ Hearing disorder	☐ Endocrine disorder	☐ Leukemia	☐ Autism	☐ Injury to teeth or mouth
☐ Vision disorder	☐ Cancer, Tumors,	☐ Bacterial or Viral infections	☐ Night grinding	☐ Transfusion: (Including
☐ Nervous disorder	Blood disorders	☐ Recurrent headaches	or TMJ problems	at birth)
☐ Bleeding disorder	☐ Lung problem	☐ Retardation	☐ Congenital Birth Defects	Approximate
☐ Cerebral palsy	☐ Brain injury	☐ Behavioral/Learning problem	☐ HIV ⊕	Date: _____

If yes to any, please explain: _____

Is your child presently taking any medicine? _____ (Name of Medication and Dose)

Is your child allergic to anything? _____ (Please List)

Has your child experienced any unfavorable reaction to medicine? ☐ Yes ☐ No

(Such as penicillin, aspirin, xylocaine) Please List: _____

Is your child presently undergoing medical treatment? ☐ Yes ☐ No _____ (Describe)

Has your child ever been hospitalized since birth? ☐ Yes ☐ No

If so please list: Date _____ Reason _____

Has your child ever had an unfavorable experience in a dental office? ☐ Yes ☐ No

Date of your child's last dental care _____ Were X-Rays taken? ☐ Yes ☐ No ☐ Don't Know

Does your child have a toothache? ☐ Yes ☐ No

Purpose of this appointment _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment _____

Your child is a minor; therefore, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. Restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health or his/her medications change, I will inform the doctor at the next appointment without fail. I realize that the parent bringing the patient to the office is responsible for payment of the account and I will be responsible for the cost of this dental care. In the event of default, I agree to pay a reasonable collection and/or attorney fee.

Date: _____ _____

Signature of person completing form and responsible for payment of account

_____ Dental Assistant reviewing history _____ Dr.

MEDICAL HISTORY