Busciglio Smiles
Orthodontics & Pediatric Dentistry

Board Certified Orthodontics & Pediatric Dentistry

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational.

ABOUT YOUR CHILD

PATIENT'S NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH _____ AGE _____ SEX M F PHONE # _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

SCHOOL _____ GRADE _____

ANYTHING ABOUT YOUR CHILD YOU WOULD LIKE US TO KNOW?

_____

_____

_____

_____

_____

_____

_____

DAD

FATHER _____ S.S. # _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ BUSINESS/CELL _____

EMPLOYER _____ OCCUPATION _____

Busciglio Smiles
Orthodontics & Pediatric Dentistry

Board Certified Orthodontics & Pediatric Dentistry

MOM

MOTHER _____ S.S. # _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ BUSINESS/CELL _____

EMPLOYER _____ OCCUPATION _____

INSURANCE

DENTAL INS. COMPANY _____

PHONE NUMBER _____ GROUP # _____

EMPLOYEE NAME _____ RELATIONSHIP TO CHILD _____

EMPLOYEE S.S. # _____ EMPLOYEE BIRTH DATE _____

EMPLOYER _____

REFERRAL

HOW DID YOU HEAR ABOUT US? _____

_____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

DENTAL HISTORY

PATIENT'S DENTIST _____

DATE OF LAST CLEANING _____ REFERRED BY DENTIST Y N

Busciglio Smiles
Orthodontics & Pediatric Dentistry

Board Certified Orthodontics & Pediatric Dentistry

PLEASE ANSWER ALL QUESTIONS

HAVE THERE BEEN INJURIES TO THE FACE, MOUTH OR TEETH? IF YES PLEASE EXPLAIN. Y ☐ N ☐

_____

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? IF YES PLEASE EXPLAIN. ☐ ☐

_____

WAS THE PATIENT BOTTLE OR BREASTFED?

_____

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? IF YES PLEASE EXPLAIN. ☐ ☐

_____

HAVE YOU EVER BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? IF YES PLEASE EXPLAIN. Y ☐ N ☐

_____

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? IF YES PLEASE EXPLAIN. ☐ ☐

_____

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? IF YES PLEASE EXPLAIN. ☐ ☐

_____

IS THE PATIENT A MOUTH BREATHER? ☐ ☐
WHILE AWAKE? ☐ ☐
WHILE ASLEEP? ☐ ☐

PLEASE CHECK BELOW IF YOU OR YOUR CHILD HAS HAD PROBLEMS OR CONCERNS WITH ANY OF THE FOLLOWING:

☐	CAVITIES	☐	GUM INFECTION	☐	GRINDING/ BRUXISM	☐	TOOTH SENSITIVITY	☐	CROOKED TEETH
☐	TOOTHACHE	☐	CANKER SORES	☐	JAW PAIN	☐	TOOTH COLOR	☐	MISSING TEETH

WHEN WAS YOUR CHILD'S LAST DENTAL VISIT? _____

PREVIOUS DENTIST'S NAME AND ADDRESS: _____

_____

WHY DID YOUR CHILD LEAVE HIS/HER PREVIOUS DENTIST? _____

_____

YOUR CHILD DRINKS WATER PRIMARILY FROM: ☐ PUBLIC SUPPLY COMPANY? _____

☐ WELL ☐ BOTTLED: FLOURIDE OR NON FLOURIDE

Y N	DOES YOUR CHILD USE TOOTHPASTE WITH FLOURIDE?	Y N	DO YOU HAVE A REVERSE OSMOSIS WATER FILTER?*	*PRESCRIBED BY	
Y N	DOES YOUR CHILD USE FLOURIDE RINSES?	Y N	DOES YOUR CHILD TAKE PRESCRIPTION FLOURIDE TABLETS/ DROPS?*	*TYPE/DOSAGE?	

MEDICAL HISTORY

PATIENT'S PHYSICIAN _____

DATE OF LAST PHYSICAL EXAM _____ RESULTS _____

ARE PATIENTS IMMUNIZATIONS UP TO DATE? Y N

Busciglio Smiles
Orthodontics & Pediatric Dentistry

Board Certified Orthodontics & Pediatric Dentistry

PLEASE ANSWER ALL QUESTIONS:

Y N	DOES PATIENT HAVE A HEALTH PROBLEM?	Y N	IS PATIENT ALLERGIC TO ANYTHING? (FOOD, POLLEN, ANIMALS, DUST)
Y N	HAS PATIENT BEEN ILL RECENTLY?		IF YES, WHAT?
Y N	HAS PATIENT BEEN UNDER TREATMENT BY A PHYSICIAN RECENTLY?	Y N	DOES THE PATIENT HAVE ALLERGIES OR UNFAVORABLE REACTION TO ANY MEDICINES? (PENICILLIN, ASPIRIN, DEMEROL, ACETAMINOPHEN, CODEINE OR IBUPROFEN?)
	IF YES, FOR WHAT REASON?		IF YES, WHAT?
Y N	HAS PATIENT BEEN IN A HOSPITAL?	Y N	HAS YOUR CHILD EVER HAD PRE-MEDICATION WITH ANTIBIOTICS BEFORE DENTAL APPOINTMENTS?
	IF YES, FOR WHAT REASON?	Y N	DOES PATIENT HAVE GOOD PHYSICAL COORDINATION?
Y N	DOES PATIENT TAKE ANY MEDICINES?	Y N	HAS PATIENT EVER HAD BLOOD OR BLOOD PRODUCT TRANSFUSION?
	IF YES, WHAT KIND?		

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH OR TREATED FOR THE FOLLOWING?

Y N	ACID REFLUX	Y N	BREATHING PROBLEMS	Y N	HEART CONDITION/ DISEASE	Y N	RHEUMATIC FEVER
Y N	ADHD /HYPERACTIVITY	Y N	CANCER/TUMOR/ MALIGNANCY	Y N	HEART MURMUR	Y N	SEIZURES/EPILEPSY
Y N	ALLERGIES	Y N	CEREBRAL PALSY	Y N	HEPATITIS	Y N	SICKLE CELL DISEASE
Y N	ANEMIA	Y N	CHEMOTHERAPY/ RADIATION	Y N	HIV/AIDS	Y N	SINUS PROBLEMS
Y N	ARTHRITIS	Y N	CLEFT LIP/PALATE	Y N	KIDNEY DISEASE	Y N	SPEECH DELAY
Y N	ASTHMA	Y N	DEVELOPMENTAL DELAY	Y N	LATEX SENSITVITY/ ALLERGY	Y N	TONSILECTOMY/ ADENOIDECTOMY
Y N	AUTISM	Y N	DOWN SYNDROME	Y N	LIVER DISEASE	Y N	TRANSPLANT
Y N	BIRTH DEFECTS	Y N	DIABETES	Y N	MENTAL RETARDATION	Y N	TUBERCULOSIS
Y N	BLADDER DISEASE	Y N	GI/STOMACH DISEASE	Y N	MENTAL/NERVOUS DISORDER	Y N	VISION PROBLEMS
Y N	BLEEDING PROBLEMS	Y N	HEARING IMPAIRMENT	Y N	PREMATURE BIRTH	Y N	OTHER

Thank you for filling out this form completely! It will enable us to give your child the best care possible. If you or your child have any questions, please feel free to ask us at any time!

IF OTHER, PLEASE SPECIFY _____

PLEASE PROVIDE MORE INFORMATION ON ANY OF THE ABOVE MARKED YES: _____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION WE SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED: _____

I UNDERSTAND THE INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN THE MEDICAL STATUS. I ALSO AUTHORIZE THE STAFF TO PERFORM THE NECESSARY SERVICES NEEDED FOR MY CHILD/SELF.

_____ DATE

_____ PATIENT/PARENT SIGNATURE