Purcellville Pediatric Dentistry

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Patient Registration Form

Welcome to The Tooth Fairy Dentist! Please complete this form for each of your children. Thank you.

Patient Name: ______________________ * ______________________ * ____ ______________________
Last First MI Preferred Name

Date of Birth: * ____________

Please check all that may apply for your child:

- [ ] *Pre-Med
- [ ] ADD/ADHD
- [ ] Allergies
- [ ] Asthma
- [ ] Autism
- [ ] Blood Disorder
- [ ] Cancer
- [ ] Developmental Delay
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Hearing Impairment
- [ ] Heart Disease
- [ ] Heart Murmur (INNCT)
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Hypoglycemia
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Muscle Tone
- [ ] Mental Health Dx
- [ ] Nervous Disorders
- [ ] Physical Disability
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Speech Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] x - OTHER

Please explain/clarify any conditions selected above:

____

____

Are there any other health concerns we should be aware of?

____

____

Are there any other allergies?

____

____

Please list any medications you are currently taking, one medication per line:

____

____

____

____

Name of the patient's physician and the practice phone number:

____

____

Name of your preferred pharmacy and the phone number:

____

____

What is the reason for seeing the dentist today?

☐ First visit ☐ Check-up ☐ Pain ☐ Other

Has your child been to a different dental office in the last 6 months? ◯ Yes ◯ No

If yes, please provide the dentist's name and practice phone number:

____

____

When was your child's last dental visit? ____________

How frequently does your child brush their teeth?

◯ 3+ per day ◯ Twice per day ◯ Once per day ◯ Less than once per day

Who brushes your child's teeth?

◯ Parent ◯ Child ◯ Both

Is your child taking a fluoride supplement? ◯ Yes ◯ No

How often does your child floss?

◯ Daily ◯ A few times per week ◯ Weekly ◯ Seldom ◯ Never

Who flosses your child's teeth?

◯ Parent ◯ Child ◯ Both

Does your child do any of the following?

☐ Grinding teeth ☐ Lip sucking/biting ☐ Nail biting ☐ Nursing/bottle ☐ Pacifier ☐ Snoring
☐ Thumb/finger sucking

Is there anything you would like to discuss with the dentist alone or away from your child?

____

____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Name of person completing this form: *

____

____

Relationship to patient: *

◯ Mother ◯ Father ◯ Guardian ◯ Other

Response Date: ___________