Sorenson Dental

14688 Everton Ave N | Suite 104 • Hugo, MN 55038 (651)204-0201

New Patient Information

Please let us know about your child's medical and dental history so that we may serve you more effectivly and in a manner that helps with the overall health and well-being of your child.

Patient Name: ______________________ ______________________ ___ ______________________
Last First MI Preferred Name

Date of Birth: ____/____/_____ Sex: M F

Address: ________________________________ ________________________________
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Phone: ____________ ____________ ____________ ______ **Best time to call:** ______________
Home Mobile Work Ext

Who does the child live with?

☐ Mother ☐ Father ☐ Grandparents ☐ Other

Is there anything you would like to discuss about your child with the Dentist/staff away from your child? ◯ Yes ◯ No

Guardian Information

Unless information is different, this information need be only completed for one child.

Name: ________________________________ **DOB:** ____/____/_____

Parent's Marital Status:

◯ Married ◯ Divorced ◯ Separated ◯ Single ◯ Widowed

◯ Mother ◯ Step-Mother ◯ Guardian

Address if different from patient: ____

Home Phone: (____) _____-______ Cell: (____) _____-______ Work: (____) _____-______

Employer: ________________________________

◯ Father ◯ Step-Father ◯ Guardian

Name: ________________________________ **DOB:** ____/____/_____

Parent's Marital Status:

☐ Married ☐ Divorced ☐ Seperated ☐ Single ☐ Widowed

☐ Father ☐ Step-Father ☐ Guardian

Address if different from paitent: ____

Home Phone: (____) _____-______ Cell: (____) _____-______ Work: (____) _____-______

Employer: ________________________________

Emergency contact

Name: ________________________________ Relationship to patient: ______________________

Home Phone: (____) _____-______ Cell: (____) _____-______ Work: (____) _____-______

Medical History

Child's Physician: ______________________ Clinic: ______________ Date of last visit: ____/____/______

Is your child under the care of a physician? ◯ Yes ◯ No

If yes, explain: ____

Are immunizations current? ◯ Yes ◯ No

Please list all the medications/foods/other that your child is allergic to:

____

Has the child been diagnosised with or treated for any of the following (check all that apply):

☐ Abnormal bleeding	☐ AIDS/HIV+	☐ Anemia	☐ Any hospital stays/surgeries
☐ Asthma	☐ Blood transfusion	☐ Cancer	☐ Cerebral Palsy
☐ Cleft palate/lip	☐ Diabetes	☐ Epilepsy/Seizures	☐ Handicaps/disabilities
☐ Hearing/ speech impairment	☐ Heart disease	☐ Heart murmur	☐ Hemophilia Type _____
☐ Hepatitis Type _____	☐ High/low blood pressure	☐ Hives	☐ Kidney problems
☐ Liver problems	☐ Rheumatic fever	☐ Sickle Cell Anemia	☐ Tuberculosis

Dental History

Is the child currently having problems with any of the following?

◯ Cavities	◯ Gum infection	◯ Toothache
◯ Color of teeth	◯ Sensitive teeth	◯ Tooth Alignment
◯ Trauma	◯ Other ____________________	

Has the child experienced problems with previous dental work? Y N Explain: ________________
Is the child's home water supply fluoridated? Y N
Does the child brush their teeth daily with fluoride toothpaste? Y N
Does the child floss daily? Y N
Does the child suck their finger/ thumb/ pacifier/ or exhibit other habits? ___________

What would you say the child's overall thoughts about the dentist appear to be:

☐ Fearful ☐ Helpful ☐ Cooperative

All effort will be made to obtain the cooperation of child dental patients by the use of Tell-Show-Do with friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient causing injury to themselves, it may be necessary to use other anxiety reducing techniques. Which include but are not limited to the use of Nitrous Oxide gas (laughing gas), voice alteration, mouth prop, and/or rubber dam. If these techniques are unsuccessful in providing safe and effective care, the patient will be referred to a pediatric dentist.

To the best of my knowledge, all the preceding information is true and correct. If the child has any change in their health, I will inform the office at my next dental appointment without fail.

Signature ____ **Date** __________

Relationship to patient: ____________________

Doctor Signature: ______________________________ **Date:** ____/____/______

Response Date: ____/____/______