CDC Of New Hampshire
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Amherst, NH 03031
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Children's Dental Center of New Hampshire and Orthodontics

Patient Personal Information

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

ALLERGIES

Allergic to Antibiotics?

- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Azithromycin
- ☐ Y ☐ N Bactrim
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Other: See Medical Questions

Allergic to Other Medications?

- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Other: See Medical Questions

Other Types of Allergies?

- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Food Allergy
- ☐ Y ☐ N Gluten
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Bruising Easily
- ☐ Y ☐ N Kidney Problems

Brain (Neurological) Health

- ☐ Y ☐ N ADHD/ADD
- ☐ Y ☐ N Anxiety
- ☐ Y ☐ N Autism Spectrum Disorder (ASD)
- ☐ Y ☐ N Cerebral Palsy
- ☐ Y ☐ N Down Syndrome
- ☐ Y ☐ N Epilepsy/ Seizures
- ☐ Y ☐ N Growth/Development Problems
- ☐ Y ☐ N Mental Health Conditions
- ☐ Y ☐ N Neurological Disorders
- ☐ Y ☐ N Sensory

Cancer

- ☐ Y ☐ N Cancer/Tumor or Growth

Digestive Health

MEDICATIONS

- ☐ Y ☐ N Birth Control
- ☐ Y ☐ N Premedication
- ☐ Y ☐ N Medication List Provided

CHILD DEVELOPMENT

- ☐ Y ☐ N Birth Defects
- ☐ Y ☐ N Child Abuse
- ☐ Y ☐ N Cleft Lip / Palate
- ☐ Y ☐ N Clenching / Grinding Teeth
- ☐ Y ☐ N Lip Sucking / Biting
- ☐ Y ☐ N Metal Pins/Plates
- ☐ Y ☐ N Mouth Breather
- ☐ Y ☐ N Nail Biting
- ☐ Y ☐ N Nursing Bottle Habits
- ☐ Y ☐ N Thumb/Finger Sucking
- ☐ Y ☐ N Tongue Thrust
- ☐ Y ☐ N Milk Leaks While Feeding
- ☐ Y ☐ N Pacifier Won't Stay in Mouth
- ☐ Y ☐ N Poor Weight Gain
- ☐ Y ☐ N Reflux (Clicking/Swallows Air)
- ☐ Y ☐ N Sleeps Upright Only / Carseat
- ☐ Y ☐ N Slides Off While Latching
- ☐ Y ☐ N Sucking Blisters/Lip Callouses
- ☐ Y ☐ N Wakes Congested (AM/Nap)
- ☐ Y ☐ N Wakes Every 1-2 Hours to Feed
- ☐ Y ☐ N Other: See Medical Questions

NURSING MOTHERS ONLY

- ☐ Y ☐ N Baby Gumming / Chewing Nipples

☐ Y ☐ N Nuts
☐ Y ☐ N Seasonal Allergies
☐ Y ☐ N Other: See Medical Questions

Heart (Cardiac) Health

☐ Y ☐ N Cardiovascular Disease
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Heart Murmur

Breathing (Respiratory) Health

☐ Y ☐ N Asthma
☐ Y ☐ N Snoring

Blood (Circulatory) Health

☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Anemia

☐ Y ☐ N Acid Reflux/ GERD
☐ Y ☐ N Celiac Disease
☐ Y ☐ N Gastrointestinal Disease

Eye, Ear, Nose, Throat

☐ Y ☐ N Blindness
☐ Y ☐ N Ear Infections
☐ Y ☐ N Hearing / Speech Problems

Autoimmune Disease

☐ Y ☐ N HIV Infection
☐ Y ☐ N Autoimmune Disease

Chronic Disease

☐ Y ☐ N Diabetes Type 1
☐ Y ☐ N Diabetes Type 2

QUESTIONS BELOW ONLY FOR LIP/TONGUE TIE CONSULT INFANT PATIENTS

☐ Y ☐ N Always Seems Hungry
☐ Y ☐ N Apnea / Snoring, Noisy Breaths
☐ Y ☐ N Colic Symptoms / Cries Often
☐ Y ☐ N Difficulty Achieving Latch
☐ Y ☐ N Falls Asleep w Nursing Attempt
☐ Y ☐ N Frustrated by Breast/Bottle
☐ Y ☐ N Gags Introducing Solid Food
☐ Y ☐ N Gags/Coughs/Chokes When Eating
☐ Y ☐ N Gassy
☐ Y ☐ N Lips Curl Under When Eating
☐ Y ☐ N Decreasing Milk Supply
☐ Y ☐ N Feeling Depressed/Hopelessness
☐ Y ☐ N Infected Nipples or Breast
☐ Y ☐ N Mastitis / Inflammation
☐ Y ☐ N Nipples Bleeding or Cut
☐ Y ☐ N Nipples Thrush
☐ Y ☐ N Oversupply of Breastmilk
☐ Y ☐ N Painful Latch Onto Breast
☐ Y ☐ N Plugged Ducts / Engorgement
☐ Y ☐ N Secure Latch Not Possible
☐ Y ☐ N Other: See Medical Questions

Additional Comments

Dental Questionnaire

How do you expect your child to react today? (calm, nervous, excited, unsure, needs support) _____

Dental History

Name of Previous Dentist? _____

When was the patient's last cleaning? _____

When were the patient's last dental x-rays taken? _____

Do you help your child brush? _____

Do you help your child floss? _____

Has the patient ever had trauma or injury to the mouth, teeth, or chin? Explain. _____

Has the patient had an unpleasant dental experience or a problem with past dental work? Explain. _____

Is your home on town/city water? _____

Is your home on well water? _____

Medical Questionnaire

Pediatician's Name _____

Pediatrician's Telephone/ Office Address _____

Are immunizations current? _____

Has there been a recent change to the patient's health? Explain. _____

Has the patient been hospitalized or had a serious illness within the past 5 years? Explain. _____

Is the patient currently taking any prescription or over the counter drugs? _____

List Medications:	
Pharmacy Name:	
Pharmacy Phone Number:	
Pharmacy Address:	
Does your child have heart disease / malformation / murmur?	
Additional allergies (if not included in medical history, including food types)	
Any disease, condition, or problem not listed in medical history? Please list.	
INFANTS ONLY BELOW	
Did you sign a waiver refusing vitamin K at birth?	
Current weight (lbs/oz)	
Feeding History (e.g. - chose not to breastfeed / currently breastfeeding / supplement with bottle)	
Lactation Consultant Name	
Lactation Consultant Phone	
Lactation Consultant Email	
CONSULT LIP/TONGUE TIE	
Has a pediatrician evaluated lip / tongue tie?	
Any prior surgery to correct lip / tongue tie?	
If yes, date of surgery	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**