Carr Pediatric Dentistry
Driving you to better dental health

Our mission is to practice evidence-based dentistry (the integration of best evidence with clinical judgment and expertise) implementing a philosophy that is based on a commitment to preventive dentistry and education. We aim to create a supportive and nurturing environment while providing safe, comfortable and quality dental treatment for children.

ABOUT YOUR CHILD

Child's Name: _____
Nickname:_____ ☐Male
DOB: _____ Age:_____ ☐ Female
SS# _____
Home Address: _____
_____
Home Phone: (____) _____
School: _____Grade: ____
Sibling Names: _____
_____
Child lives with ☐Mother ☐ Father ☐Both ☐Other
Emergency Contact:_____
Phone#: _____

PARENT INFORMATION

Mother's Name: _____
DOB: _____ Age:_____SS# _____
Employer: _____
Work Phone: (____) _____
Cell Phone: (____) _____
Email: _____

Father's Name: _____
DOB: _____ Age:_____SS# _____
Employer: _____
Work Phone: (____) _____
Cell Phone: (____) _____
Email: _____

INSURANCE INFORMATION (Primary)

Insured's Name: _____
Date of Birth:_____
Social Security Number: _____
Employer: _____
Insurance Co. Name:_____
Insurance Co. Address: _____
_____
Insurance Co. Phone: (____) _____
Group Plan/ Number: _____
_____

INSURANCE INFORMATION (Secondary)

Insured's Name: _____
Date of Birth:_____
Social Security Number: _____
Employer: _____
Insurance Co. Name:_____
Insurance Co. Address: _____
_____
Insurance Co. Phone: (____) _____
Group Plan/ Number: _____
_____

Dental History

Are Immunizations Current? ☐Yes ☐No
Has your child ever had any of the following:
Trouble with previous dental visits? ☐Yes ☐No
TMJ Pain? ☐Yes ☐No
Bad Breath? ☐Yes ☐No
Frequent sores on lips or mouth? ☐Yes ☐No
Taking fluoride supplements? ☐Yes ☐No
Pain or sensitivity in his mouth? ☐Yes ☐No

Is there any other problem not covered in this section that you would like to discuss? ☐Yes ☐No
Please specify: _____
_____

Reason for your visit today: _____
_____

Dental History

Has your child ever had any of the following habits:
Lip sucking/ biting? ☐Yes ☐No
Nail biting? ☐Yes ☐No
Thumb/ finger sucking? ☐Yes ☐No
Uses pacifier? ☐Yes ☐No
Tongue thrust? ☐Yes ☐No
Grinding or Clenching? ☐Yes ☐No
Currently breast feeding? ☐Yes ☐No
Frequent bottle use or night feedings? ☐Yes ☐No
Tongue or cheek biting? ☐Yes ☐No

Who referred you to our office? _____
_____
Date of last dental visit: _____
Name of previous dentist: _____