HIGH HOUSE PEDIATRIC DENTISTRY **RAYMOND J TSENG, DDS, PhD**
351 Wellesley Trade Lane, Suite 212, Cary, NC 27519: 919-267-4211: smiles@highhousepedo.com

PATIENT DEMOGRAPHIC INFORMATION

Patient: _____ Today's Date: _____
Pt. Preferred Name: _____ Patient Dob: _____ Ethnicity: _____
Address: _____ City/State/Zip: _____
Names and Ages of other children in the family: _____
School _____ Grade: _____ Sex: M F

Parent/Legal Guardian Contact Information

Parent/Guardian Name: _____ Relation to Pt: _____
H #: _____ W #: _____ Employer: _____
C #: _____ Text Msg Capable: ☐ Yes ☐ No Camera/Pic Capable: ☐ Yes ☐ No
Address: Same as Above? ☐ Yes ☐ No _____
Parent/Guardian Email: _____

Parent/Guardian Name: _____ Relation to Pt: _____
H #: _____ W #: _____ Employer: _____
C #: _____ Text Msg Capable: ☐ Yes ☐ No Camera/Pic Capable: ☐ Yes ☐ No
Address: Same as Above? ☐ Yes ☐ No _____
Parent/Guardian Email: _____
Who has legal custody of the patient? _____

How may we contact you for appointment reminders (please circle all that apply)?
Home # Work # Cell # Text (via Cell) Email
Dental Insurance: ☐ Yes: Insur Name: _____ ☐ No
Person responsible for payment of account: _____ SS #: _____
Who may we thank for referring you to our practice? _____
What is the reason for your child's dental visit? _____

Health History

Name of Child's Physician/Group: _____Phone #: _____
Mailing Address: _____
City/State/Zip: _____

☐ Yes ☐ No Is your child in good health? Date of last physical exam: _____
☐ Yes ☐ No Has your child ever been hospitalized?
Please give dates and reasons: _____
☐ Yes ☐ No Is your child allergic to anything?
Please list: _____
☐ Yes ☐ No Is your child taking any medications?
List name/dose/reason: _____
_____
_____
☐ Yes ☐ No Are your child's immunizations current?
☐ Yes ☐ No Were there any problems at birth? _____

Parent/Guardian Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY INFORMATION

Please indicate if your child has/has been treated for any of the following:

☐ AIDS/HIV	☐ Cancer/Tumors	☐ Frequent Infections	☐ Overweight/Obesity
☐ ADHD/ADD	☐ Cerebral Palsy	☐ Heart Disease/Murmur	☐ Personality/Social
☐ Adverse Drug Rxns	☐ Cleft Lip/Palate	☐ Hepatitis	☐ Physical Delays
☐ Anemia	☐ Congenital Birth Defects	☐ Kidney Disease	☐ Reflux/GERD
☐ Asthma/Breathing	☐ Diabetes	☐ Liver/GI Disease	☐ Rheumatic Fever
☐ Autism/ASD	☐ Down's Syndrome	☐ Mental Delays	☐ Seizures
☐ Bleeding/Transfusions	☐ Endocrine/Growth	☐ MRSA	☐ Speech/Hearing
☐ Blood Dyscrasias	☐ Eyesight	☐ Opp. Defiance Disorder	☐ Other Problems

Please elaborate/list other health issues: _____

_____

Do you consider your child's learning process to be: ☐ Advanced ☐ Normal ☐ Delayed

Was your child? ☐ Breast-Fed (stopped at _____ yrs age) ☐ Bottle-Fed (stopped at _____ yrs age)

Dental History

☐ Yes ☐ No Has your child been to a dentist? Last Xrays: _____ Last Exam: _____
Practice/Dentist Name: _____

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care?
Explain (anxiety,fear,etc): _____

☐ Yes ☐ No Does your child suck a finger, thumb, or pacifier?

☐ Yes ☐ No Does your child have pain or popping associated with chewing, yawning, or opening wide?

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride?

☐ Yes ☐ No Does your child participate in a school fluoride rinse program?

Please check if your child is having any of these problems or you have concerns with any of these problems:

☐ Cavities	☐ Jaw Sounds	☐ Sensitive Teeth	☐ Toothache
☐ Grinding	☐ Mouth Odor	☐ Teeth Color	☐ Trauma
☐ Gum Infection	☐ Orthodontics	☐ Teeth Not Falling Out	☐ Other

Consent to Dental Treatment

I am the parent/guardian/personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information provided on patient is complete and accurate to the best of my knowledge.

I give consent for Dr. Raymond J Tseng, associated dentist(s), & staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problems. For the purposes of dental research and the advancement of medical/dental education, I will allow photographs to be taken of my child or child's teeth for diagnostic, educational, and research purposes. All information contained in dental chart may be used for educational or research purposes. I am fully aware that any treatment and fees may change, that I will be responsible for any charges incurred on this child for dental treatment, and that payment is expected in full at the time of service. I understand it is my responsibility to inform High House Pediatric Dentistry of any changes in my child's medical status.

Parent/Guardian Signature: _____ **Date:** _____