Barry Reder, DDS
Seth Reder, DDS

Patient Introduction Form

This confidential information is of great value in aiding us to better understand and treat your child.

REASON FOR VISIT: ______________________ Date: ___/_______

Child's Name: ______________________ Nickname: __________ Sex: M F

Age: ______ Date of Birth: ________ School: ______________ Grade: _____

Name(s) and Age(s) of brothers: ______________________

Name(s) and Age(s) of sisters: ______________________

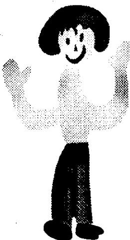
Child's Physician: ______________________ City: ______________

Date last seen by physician (month/year): ______________________

Family Dentist: ______________________ City: ______________

Where did you hear about our office? ______________________

MEDICAL HISTORY



	Yes	No
1. Is your child presently under the care of a physician?................................. For what reason? ______________	☐	☐
2. Is your child currently taking medication?.. Medicine ______________ Dosage ______________	☐	☐
3. Has there been any change in his/her general health within the past year?	☐	☐
4. Is your child sensitive or allergic to any drug (e.g. penicillin)?.................	☐	☐
5. Does your child have a history of allergic reactions or allergy?.................	☐	☐
6. Is your child subject to any nervous disorders, fainting, or dizziness?......	☐	☐
7. Is your child subject to any blood or bleeding disorders?...........................	☐	☐
8. Does your child bruise easily?..	☐	☐
9. Has your child had a history of heart trouble or murmurs, rheumatic fever, diabetes, asthma, epilepsy, tuberculosis, brain injury, kidney, liver, lung or other problem that should be brought to the doctor's attention?.......	☐	☐
10. Has your child ever been hospitalized or had surgery?............................. Reason: ______________ When: __________	☐	☐
11. Does your child have a handicapping problem or learning disabilities?...	☐	☐
12. Has your child been diagnosed with or does he/she display any symptoms of mental/behavior challenges (i.e. Autism, ADD, etc)?______________	☐	☐

DENTAL HISTORY

	Yes	No
1. Is this your child's first dental visit?... Previous dentist: __________ City: __________ Date last seen:________	☐	☐
2. Has your child had an unfavorable experience in a previous dental office?	☐	☐
3. How do you think he/she will act toward the dentist?______________		
4. Does your child have a problem with his/her bite position of any teeth?...	☐	☐
5. Has your child been seen by an orthodontist?...	☐	☐
6. Have their been any injuries to your child's teeth or jaws(falls, chips, etc)?	☐	☐
7. What do you believe is the cause for tooth decay? (please check) ☐Heredity ☐Tooth-brushing habits ☐Excessive sweets ☐Other__________		
8. Has Mother or Father experienced a great amount of tooth decay?..........	☐	☐
9. How often did your child brush his/her teeth yesterday?______________		
10. Is dental floss used?..	☐	☐
11. Is your child taking a fluoride supplement or drinking fluoridated water?	☐	☐
12. Are you interested in preventing further decay by having fluoride treatments?...	☐	☐
13. Has your child a history of any of the following? (please check) ☐thumb/finger sucking? ☐lip sucking ☐nail biting ☐pacifier..........	☐	☐
14. What is your child most interested in? ______________ *(toys, dolls, hobbies, etc)*		
15. Name and type of pets? ______________		
16. Is your child adopted?.. Does he or she know? ☐YES ☐NO	☐	☐

17. Please use the back of this sheet for any comments, questions, or requests that you would like to bring to my attention or to amplify any of the information given

above if additional space is needed.

FAMILY HISTORY RECORD

Address__________________________ City______________ State_____ Zip_______

Residence Phone______________________ Cell/Other Phone______________________

Father's Full Name__________________________ Soc. Sec.#____________________

Address (if different)______________________________ Date of Birth__________

Occupation________________________ Employed by__________________________

Bus. Address______________________ City____________ Bus Phone____________

Mother's Full name__________________________ Soc. Sec.#____________________

Address (if different)______________________________ Date of Birth__________

Occupation________________________ Employed by__________________________

Bus. Address______________________ City____________ Bus Phone____________

Nearest relative not living with child: Name_____________________________

Address______________________________________ Phone________________