Welcome to Dr. Cynthia M. Elberty, D.D.S Family Dentistry
1 Brooklyn Road
Freeville, NY 13068

Today's date: _____

1. Patient information

Patient's name: _____ Male Female
First Last
Birthday ___/___/___ Age _____
Address _____
School _____ Grade _____
Siblings that we treat _____

2. Mother's information: Mother Stepmother Guardian

Mother's name _____ Date of birth _____
Employer _____ Work phone _____
Home phone _____ Cell phone _____ Email _____
Address _____

3. Father's information: Father Stepfather Guardian

Father's name _____ Date of birth _____
Employer _____ Work phone _____
Home phone _____Cell phone _____ Email _____
Address _____

4. Person responsible for account

Name _____ Relationship _____
Phone _____ Address _____

5. Primary dental insurance

Policy holder's name _____ ID# _____
Policy holder's employer _____ Group # _____
Insurance company's name _____
Insurance company's address _____
Insurance company's phone _____

6. Primary care physician

Name _____ Phone number _____

(over)

Child's name:

Age:

Child's health history: Children under 5

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? Y N
   If yes please list: _____
2. Is the child currently being treated for any illness? _____ Y N
3. Is the child allergic to any medications: i.e. Penicillin, antibiotics, or other drugs? Y N
*If yes explain*_____
4. Is the child allergic to anything else such as certain foods? *If yes explain:* _____ Y N
5. Has the child ever had a serious illness? *If yes when?* _____ *Please explain* _____ Y N
6. Has the child ever been hospitalized or had any operations? _____ Y N
7. Does the child have a history of any other illnesses? *If yes explain* _____ Y N
8. Is the child physically, mentally or emotionally impaired? _____ Y N
9. Does your child have speech difficulties? Y N
10. Has your child needed pre-medication w/ antibiotic prior to past dental visits? Y N
11. What is your child's immunization status? _____

Has the child ever had any history of or conditions related to any of the following? Circle Y or N.

Y N Anemia	Y N Abnormal Bleeding	Y N Asthma	Y N ADD/ADHD
Y N Bones/Joints	Y N Cerebral Palsy	Y N Chicken Pox	Y N Chronic Sinusitis
Y N Diabetes	Y N Epilepsy/ Convulsions	Y N Fainting	Y N Growth Problems
Y N Autism	Y N Rheumatic/ Scarlet Fever	Y N Sickle Cell	Y N Thyroid
Y N Hepatitis	Y N Heart Disease/ Murmur	Y N Tuberculosis	Y N HIV/AIDS
Y N Ear Aches	Y N Immunizations	Y N Mononucleosis	Y N Kidney/Liver
Y N Latex Allergy	Y N Frequent Vomiting	Y N Congenital Birth Defects _____	

Y N Disabilities/ Special Needs _____
Y N Has your child ever has any illness or condition not listed above? _____

Dental health questionnaire for children under 5

There are many important factors that can affect a child's dental health. The top three things that are most important to a child's developing teeth are as follows: home care (tooth brushing, flossing and the use of fluoride), any habits relating to the mouth or teeth, and your child's diet. ***To help us better evaluate your child's dental health please answer the following questions:***

Child's dental history

1. Is this the child's first visit to the dentist? Y N If not when was the date of the LAST dental visit? _____
   Previous dentist's name _____
2. Has the child ever had any problem with dental treatment in the past? _____ Y N
3. Has the child ever had dental x-rays? Y N If yes approximate date _____
4. Has the child ever suffered any injuries to the mouth, head or teeth? _____ Y N
   If yes please explain _____
5. Has the child ever had any problems with the eruption of "baby" teeth? _____ Y N
6. Has your child ever lost any "baby" teeth? Y N *If yes, naturally?* Y N
7. Is there a family history of congenially missing teeth? _____ Y N
8. Is the child *currently* complaining of discomfort in the mouth? _____ Y N
9. Has the child *ever* complained of discomfort in the mouth? _____ Y N
10. Is there anything you are concerned about in your child's mouth? _____ Y N
    _____

(over)

Child's name:

Age:

Dental home care (Children under 5)

Does your child brush his/her own teeth? Y N _____ times per day _____ times per week Before bed? Y N
Do you brush your child's teeth? Y N _____ times per day _____ times per week Before bed? Y N
Do you floss your child's teeth? Y N _____ times per day _____ times per week
Does your child use fluoride toothpaste? Y N
How much toothpaste do you use? _____
Does your child swallow it? Y N
Home water source: Village or well? If well have you ever tested for fluoride in well water? Y N
Has your child ever lived in a fluoridated water area? Y N * Dryden Village & Bolton Point water sources are naturally fluoridated*
If yes what age? _____ How long? _____
Does/did your child take fluoride drops or tablets? Y N
If yes at what age did he/she start taking them? _____ At what age did he/she stop taking them? _____
Does your child use a fluoride mouthwash/rinse? Y N Brand name _____
Is there anything else you would like to add about the care of your child's teeth at home? _____
_____

Habits

Did/does your child suck his/her thumb/finger? Y N Did/does your child suck on a pacifier? Y N
Stopped at age _____ Still does _____ Only at night _____
Does your child have a tendency to chew pencils or other foreign objects? Y N If yes explain _____
Does your child chew ice? Y N
Does your child grind his/her teeth? Y N If yes: Daytime Night (circle)
Does your child have any other tooth related habits? _____
Does your child participate in sports or recreational activities? Y N _____
Does he/she wear a mouth guard appliance during sporting activities? Y N _____

Diet

Was/is your child put to bed with a bottle? Y N
If yes what was in the bottle? _____
Was/is your child allowed to carry a bottle or cup throughout the day containing something other than water? Y N
If yes what liquid was usually consumed? _____
How many meals per day does your child eat? _____
How many between meal snacks (including drinks other than water) does your child have on an average day? _____
Does your child have raisins, fruit rollups, fruit snacks, sour candy, sticky candy, breath mints or suckers? Y N
If yes please circle the ones that are applicable. Most frequent sweet treat? _____
Does your child chew gum with sugar in it? Y N
If yes how often? _____ times per day? _____ times per week? _____
What is your child's drink of choice with meals? _____ between meals? _____
Does your child drink: Soda Y N Sports drinks? Y N Juice Y N "Water beverages" Y N
Would you like to make any comments about your child's diet?_____
_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. After a discussion of the recommended treatment I authorize the dental staff to perform necessary dental services my child may need.

Signature of parent or guardian _____ Date _____ Relationship _____