Great Beginnings

PEDIATRIC & ORTHODONTIC DENTAL SPECIALISTS

William L. Chambers, DDS, MS, PA, Diplomate • Angela P. Baechtold, DDS, MS, PA, Diplomate
Ryan J. Haldeman, DDS, MS, PA • Douglas B. Pratt, DDS, PA, Diplomate • Stephanie S. Chambers, DDS, MS, MSD, Diplomate
Laura P. Hogue, DDS • Stephen G. Chadwick, DDS, MSD, MPH, Diplomate • Jonathan E. Wyble, DMD

Dear Parents:

We welcome you to our practice! In our effort to provide the highest quality dental care for your child, we have enclosed documents associated with your child's upcoming Frenectomy Consult. Please complete the enclosed "Welcome" packet and bring it with you along with any questions you may have about the process and procedure to the consultation appointment.

If your child has a heart murmur, heart condition or a history of any bleeding disorder, please bring medical documentation from your Pediatrician with you to your first visit. This information will be noted in your child's chart for future treatment needs.

We look forward to meeting with you and your family. Our #1 goal is to provide the very best dental experience and dental care for your child.

See you soon!

Welcome

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BeGreatDental.Com

Patient Information

Date_____

Patient's Name _____ Nickname _____ Sex_____
First Middle Last

Street Address_____

Date of Birth_____ Age _____ Weight_____ Child Lives with: { Both parents { Mother { Father { Other

Names of brothers or sisters in practice _____ School Name_____

Patient's Physician or Pediatrician Name _____ Family Dentist _____

Whom may we thank for referring you?_____

Responsible Party Information

{ Guardian { Widowed
{ Single { Separated
{ Married { Divorced

Name: _____ Marital Status:

Residential Address_____
Street City State Zip

Mailing Address_____
Street City State Zip_____

How long at this address_____ Home Ph. #_____ Cell #_____ Work Ph. #_____

{ Own { Rent Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security Number_____ Birthdate _____ Relationship to patient

Employer_____ Occupation_____ No. Years Employed_____
(if self-employed, list name of business)

Spouse/(Other) Name:_____ Relationship to Patient:_____

Address_____ Home Ph._____ Cell #_____ Work #_____

Employer_____ Occupation _____ No. Years Employed _____
(if self-employed, list name of business)

Social Security Number_____ Birthdate _____

Preferred Email Address _____

Dental Insurance Information

Policy Holder's Name_____ Policy Holder's Soc. Sec. #_____ Birthdate__/__/___

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No._____

Policy Holder's Employer _____ Do you have other dental insurance? { Yes { No

Emergency Information

Name of nearest relative not living with you _____ Phone No _____

Address_____ Relationship to patient_____
Street City State Zip

I understand that where appropriate, credit bureau reports will be obtained.

Signature_____ Date_____

Medical History

Has your child ever had any of the following? Please check those that apply:

{ HIV or AIDS { Latex Allergy { Heart Disease { Tumors or Growths
{ Hepatitis A, B, C { Mental / Nervous Disorder { Jaundice { Lung Disease or Problems
{ Asthma w/ Inhaler Use { Stroke { Anemia { Head Injury
{ Bleeding Problems { Epilepsy or Seizures { Blood Disease { Thyroid Problem
{ Blood Thinner—Aspirin / Coumadin / Other { Tuberculosis { Heart Murmur
{ Diabetes: Type ___ Last BSL? ___ Last A1C? ____ { Congenital Heart Lesion { Stomach Ulcers / GERD
{ Kidney / Liver Disease
{ Cancer: Location? _____ _____ { Other: _____
{ When Diagnosed? _____ Chemo / Radiation? (Circle)

Name of Your Baby's Doctor: _____ **Phone:** _____

□ Yes □ No Is your child taking any medications? If yes, please list name and reason on reverse side.
□ Yes □ No Has your child been told they needed to take antibiotic premedication prior to a dental appointment?
□ Yes □ No Does your child have any allergies to any medications? If yes, list : _____
□ Yes □ No Has your child been treated by a physician / hospitalized in the past year?
If yes, please explain: _____

Birth Weight: _____ Current Weight: _____ When Last Weighed: _____

About Your Pregnancy

Birth Medical Center _____

Was this your first pregnancy? Yes No If no, how many pregnancies?___

How many children do you have? _____

Did you breastfeed your other child(ren)? Yes No N/A

If yes, what was your longest previous breastfeeding experience? _____

Were there nursing problems? No Yes: _____
_____

Did the baby have any of the following after birth: NICU – Days __ Hours ___

Breathing difficulties Low blood sugar Meconium aspiration Deep suctioning
Irregular heart rate Jaundice: Highest bilirubin: _____

Is mom on any medications? No Yes If yes, what?

_____

Do you take any herbs for your milk production? No Yes, I take: Fenugreek Goat's Rue

More Milk Plus Malunggay Mother's Milk Tea Other _____

Is baby on any medications? No Yes If yes, what? _____

Dental History

Why did you bring your child to see us today? _____

Has anyone found a Tongue Tie or Upper Lip Tie in your baby? No If yes, who found it?

Lactation consultant in hospital Private practice lactation consultant Doctor

Other: _____

Is there a family history of Tongue Tie or Lip Tie on either side of the family?
No If yes, who? _____

Have you seen your baby extend the tip of the tongue out ½ inch past the lower lip?
Yes No

□ Yes □ No □ I don't know Is your child tongue-tied or lip-tied?

□ Yes □ No Is/was your child breastfed? If yes, for how long? _____

Why did you stop nursing? _____

□ Yes □ No Does your child have issues with L, T, D, N, SH, TH, or S sounds?

Does/did your child have any of the following problems? (check all that apply)

{ No effective latch-on { Un-sustained latch-on { Unable to hold pacifier
{ Slides off nipple { Prolonged feeding times { Poor weight gain or failure to thrive
{ Unsatisfied hunger after feeding { Gumming / Chewing on nipple { Falling asleep on the breast
{ Gas, colic and / or reflux, including vomiting (circle) { Upper lip blisters
{ Others: _____

Have you, the mother, experienced any of the following when breastfeeding? (check all that apply)

{ Severe pain with latch-on { Incomplete breast drainage { Mastitis or nipple thrush
{ Continued pain during nursing { Infected nipples { Reoccurring plugged ducts
{ Nipple trauma: Cracked, Bruised, Bleeding, Blistered, Creased, Blanched, or Flattened nipples (circle)
{ Others: _____

Is there anything else you would like to share about your breast feeding experience? _____

_____

_____