New Patient Form

Today's Date:

8640 W 3rd St Suite 202
Los Angeles, CA 90048

Phone: 424-322-4780
Fax: 424-322-4781

1 TELL US ABOUT YOUR CHILD

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: _____ Child's Age: _____

School: _____

Siblings We Treat: _____

Child's Home Address: _____

_____

City State Zip

Child's Home #: _____

Special Interests: _____

2 DENTAL HISTORY

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name: _____

Date of Last X-Rays at Previous Dental Visits: _____

Have there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Why did you bring your child to the dentist today?

_____

_____

_____

Does your child have any of the following habits?

- ☐ Lip Sucking / Biting
- ☐ Nail Biting
- ☐ Nursing / Bottle Habits
- ☐ Thumb / Finger Sucking
- ☐ Tobacco Use

Does your child have any current dental issues?

- ☐ Cavities
- ☐ Toothache
- ☐ Bleeding Gums
- ☐ Discolored Teeth
- ☐ Bad Breath
- ☐ Teeth Grinding
- ☐ Mouth Trauma/Broken Tooth
- ☐ Sensitivity to Hot/Cold

Has your child ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Is your child's water fluoridated? ☐ Yes ☐ No

Is your child taking fluoride supplements? ☐ Yes ☐ No

Has your child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No

3 SOCIAL HISTORY

Child's First Language: _____

Child's Second Language: _____

4 HEALTH HISTORY

Has your child ever had any of the following conditions?

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Allergies to Any Drugs
- ☐ Allergies to Latex Products
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Cancer
- ☐ Cardiac (Heart Conditions)
- ☐ Congenital Birth Defects
- ☐ Developmental Delays/ Disabilities
- ☐ Diabetes
- ☐ Hearing Impairment
- ☐ Hemophilia/Blood Disorders
- ☐ Hepatitis
- ☐ HIV + / AIDS
- ☐ Kidney/Liver Conditions
- ☐ Pregnancy
- ☐ Reflux/GI Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Tuberculosis
- ☐ None of the Above

If you checked any of the above conditions, or if you would like to discuss any other medical conditions your child has had, do so below:

_____

_____

List all drugs your child is currently taking.

_____

List all allergies your child currently has.

_____

Child's Physician: _____

Phone #: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

5 PARENT OR LEGAL GUARDIAN'S INFORMATION

The information in this section applies to the main legal caregiver of the child / children.

Name: _____

Relationship: _____ Birthdate: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

_____

City State Zip

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

SSN: _____ DL#: _____

Email Address: _____

6 SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION

(If different from #2 above.)

Name: _____

Relationship: _____ Birthdate: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

_____

City State Zip

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

SSN: _____ DL#: _____

Email Address: _____

7 HOW DID YOU LEARN ABOUT OUR PRACTICE

_____

8 WHO WILL BE ACCOMPANYING THE CHILD/CHILDREN TO THEIR APPOINTMENT?

Important Note: The parent or guardian who accompanies the child is legally responsible for payment at the time of service.

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

9 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____

City State Zip

Work #: _____

Home #: _____

Cell #: _____

Email Address: _____

10 PRIMARY DENTAL INSURANCE

Insurance Name: _____

Insurance Address: _____

_____

City State Zip

Insurance Phone: _____

Group #: _____

Policy Owner's Name: _____

Relationship: _____

Birthdate: _____

SSN: _____

Employer: _____

11 DUAL (SECONDARY) INSURANCE

Do you have dual (secondary) insurance? ☐ Yes ☐ No Insurance Name: _____

12 SIGNATURE

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Relationship to Patient

_____

Date

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

Patient Form

healthystart™

Doctor: _____

Child's Name _____ Age _____ Date: _____

Filled Out By: _____ Relationship to Patient: _____

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present 1 – 2 Mild 3 Moderate 4 - 5 Pronounced

Does your child:

	INITAL	FOLLOW UP	
1.	_____	_____	Snore at all?
2.	_____	_____	Snore only infrequently (1 night/week)
3.	_____	_____	Snore fairly often (2-4 nights/week)
4.	_____	_____	Snore habitually (5-7 nights/week)
5.	_____	_____	Have labored, difficult, loud breathing at night
6.	_____	_____	Have interrupted snoring where breathing stops for 4 or more seconds
7.	_____	_____	Have stoppage of breathing more than 2 times in an hour
8.	_____	_____	Hyperactive
9.	_____	_____	Mouth breathes during day
10.	_____	_____	Mouth breathes while sleeping
11.	_____	_____	Frequent headaches in morning
12.	_____	_____	Allergic symptoms
13.	_____	_____	Excessive sweating while asleep

	INITAL	FOLLOW UP	
14.	_____	_____	Talks in sleep
15.	_____	_____	Poor ability in school
16.	_____	_____	Falls asleep watching TV
17.	_____	_____	Wakes up at night
18.	_____	_____	Attention deficit
19.	_____	_____	Restless sleep
20.	_____	_____	Grinds teeth
21.	_____	_____	Frequent throat infections
22.	_____	_____	Feels sleepy and/or irritable during the day
23.	_____	_____	Have a hard time listening and often interrupts
24.	_____	_____	Fidgets with hands or does not sit quietly
25.	_____	_____	Ever wets the bed
26.	_____	_____	Bluish color at night or during the day
27.	_____	_____	Speech Problems *

*If yes, provide parent speech questionnaire

Was your reason for coming to this doctor for sleep or dental issues: _____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #27 was indicated above

Please check all that apply to your child:

	INITAL	FOLLOW UP	
28.	_____	_____	Is it difficult to understand your child's speech
29.	_____	_____	Difficult to understand over the phone?
30.	_____	_____	Nasal speech?
31.	_____	_____	Speech sounds abnormal?
32.	_____	_____	Others have difficulty understanding speech?

	INITAL	FOLLOW UP	
33.	_____	_____	Gets frustrated when people can't understand speech?
34.	_____	_____	Sometimes omits consonants
35.	_____	_____	Uses M, N, NG instead of P, F, V, S, Z sounds
36.	_____	_____	Hoarseness
37.	_____	_____	Lisp
38.	_____	_____	Any speech therapy?

How Long? _____

Based on Barr et al, 2007