Angela S. Lutz, D.M.D.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry

Robert W. Bowser, D.M.D.

Dear Parent/Caregiver,

We want to thank you in advance for choosing our practice for your child's first comprehensive oral examination. We are pleased to offer this service to you free of charge.*

The American Academy of Pediatric Dentistry recommends a dental home be established by the age of 12 months. The goal of the visit is to provide a thorough oral examination by one of our board certified pediatric dentists. One of our experienced clinical team members will discuss and provide written material on the following topics:

- caries prevention
- dietary recommendations
- oral hygiene instruction
- teething
- non-nutritive habits (e.g., digit and pacifier habits, bruxism, tongue thrusts)
- injury prevention

Please complete the enclosed patient registration form ahead of time and return it at the time of the appointment. We look forward to meeting you and your family!

The Staff at Children's Dental Centre of York

* (Offer applies to children 18 months of age and under)

1399 South Queen Street, Suite A York, PA 17403 (717) 741-0848 www.childrensdentalcentre.com
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Patient Registration Form
(Courtesy One Year Examination)

Date: ____/____/____

Child's Name: ______________________________ ☐ Boy ☐ Girl
Date of Birth: ____/____/____

Child's Address: ____

Mother's Information

Name________________________

(Address if different than patient)
Address ______________________

____
Phone # ______________________

Father's Information

Name________________________

Address______________________

____
Phone # ______________________

Who is accompanying child for today's appointment? ______________________

Questions regarding child's habits –

History of cavities in family members (mother, father, siblings) –

____

What does your child's daily diet include?

____

What is your child's current oral hygiene regimen include?

____

Circle current habits: Nail biting Finger/Thumb Sucking Grinding Pacifier

Is your child's water fluoridated? ☐ YES ☐ NO ☐ UNSURE
(If you are unsure, check with your water company before supplementing with a prescription. Well water is not fluoridated.)
Is your child currently taking a fluoride supplement? ☐ YES ☐ NO

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Medical History-

Does your child have or ever had any of the following diseases, conditions, or procedures?
(Please circle Yes or No)

Y N Autism
Y N Asperger's Syndrome
Y N Orthopedic Problems
Y N Hearing Problems
Y N Brain Injury
Y N Tonsils/Adenoids
Y N Hemophilia
Y N Cerebral Palsy
Y N Cleft Lip/Palate
Y N Seizures/Epilepsy
Y N Tuberculosis TB
Y N Jaw Problems/TMJ
Y N Hepatitis
Y N Artificial Bones/Joints/Implants
Y N Intellectual Disability
Y N Emotional Disturbance
Y N Nutritional Deficiency
Y N Syndrome______________
Y N ADD/ADHD
Y N High/Low Blood Pressure
Y N Rheumatic Fever
Y N Diabetes/Hypoglycemia
Y N Cancer/Tumors
Y N Artificial Heart Valves
Y N Congenital Heart Defect
Y N Heart Murmur
Y N Liver/Kidney/Organ Problems
Y N Speech Problems
Y N Jaundice
Y N Scoliosis
Y N Spina Bifida
Y N Latex Allergy
Y N HIV+/AIDS/ARC
Y N Birth Defects
Y N Transplants
Y N Leukemia/Anemia
Y N Asthma
Y N Scarlet Fever
Y N Eye Problems

Does your child have any known drug allergies? ❑ YES ____ ❑ NO

Does your child currently take any medications (prescription/over the counter)?

❑ YES ❑ NO If yes, list meds:____

Pediatrician____ Phone__________________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

____ Date ___/___/___
(Signature of parent or legal guardian)

Staff Initials:______ Date Reviewed:___/___/___ Dr. Signature__________