239 E. San Marnan Dr.
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(319) 234-2227

Jyoti Chowdhury B.D.S.

Welcome to our Practice !

CHILD'S INFORMATION

Full Name_______________ Nickname_______ M/F_____ Today's Date_______
Home Address_______________ City_______________ Zip_____ Phone_______
Birthday_____ /____/____ Age______ School_______________ Grade______ Social Security #_______________

FATHER'S INFORMATION

Name_______________ Address_______________
City_______________ State______ Zip__________ Home Phone_______________ Cell_______________
Employer_______________ Address_______________ Occupation_______________
Work Phone_______________ Social Security #_______________ DOB_______

MOTHER'S INFORMATION

Name_______________ Address_______________
City_______________ State______ Zip__________ Home Phone_______________ Cell_______________
Employer_______________ Address_______________ Occupation_______________
Work Phone_______________ Social Security #_______________ DOB_______

EMERGENCY NOTIFICATION

Person to contact in case of emergency (other than spouse).
Name_______________ Address_______________ Phone_______________
Relationship_______________

WHO'S ACCOMPANYING THE CHILD

☐ Father/Mother ☐ Legal Guardian _______________ (Name) ☐ Other _______________ (Name & Relationship)

PRIMARY & SECONDARY DENTAL INSURANCE

PRIMARY DENTAL INSURANCE COMPANY_______________
Insured's Name_______________ Relationship to patient_______________
SECONDARY DENTAL INSURANCE COMPANY_______________
Insured's Name_______________ Relationship to patient_______________

– OVER –

DENTAL HISTORY

Reason for today's visit ______________________

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Referred/Recommended by ______________________

Former Dentist ______________________

City/State ______________________

Date of last dental visit ______________________

Date of last dental X-rays ______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Bad breath ☐ Yes ☐ No
- Bleeding gums ☐ Yes ☐ No
- Blisters on lips or mouth ☐ Yes ☐ No
- Burning sensation on tongue ☐ Yes ☐ No
- Chew on one side of mouth ☐ Yes ☐ No
- Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
- Clicking or popping jaw ☐ Yes ☐ No
- Dry mouth ☐ Yes ☐ No
- Fingernail biting ☐ Yes ☐ No
- Food collection between the teeth ☐ Yes ☐ No
- Foreign objects ☐ Yes ☐ No
- Grinding teeth ☐ Yes ☐ No
- Gums swollen or tender ☐ Yes ☐ No
- Jaw pain or tiredness ☐ Yes ☐ No
- Lip or cheek biting ☐ Yes ☐ No
- Loose teeth or broken fillings ☐ Yes ☐ No
- Mouth breathing ☐ Yes ☐ No
- Mouth pain, brushing ☐ Yes ☐ No
- Orthodontic treatment ☐ Yes ☐ No
- Pain around ear ☐ Yes ☐ No
- Periodontal treatment ☐ Yes ☐ No
- Sensitivity to cold ☐ Yes ☐ No
- Sensitivity to heat ☐ Yes ☐ No
- Sensitivity to sweets ☐ Yes ☐ No
- Sensitivity when biting ☐ Yes ☐ No
- Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______________________

How often do you brush? ______________________

MEDICAL HISTORY *(If yes explain below)*

Child's Physician ______________________

Address ______________________

- Is child under care of physician now? ☐ Yes ☐ No
- Has child ever been hospitalized? ☐ Yes ☐ No
- Has child ever had surgery? ☐ Yes ☐ No
- Is child receiving any medications or drugs? ☐ Yes ☐ No List ______________________
- Is child now in poor health? ☐ Yes ☐ No
- Does your child have Heart Disease? ☐ Yes ☐ No
- Does your child have frequent "cold sores" or "fever blisters"? ☐ Yes ☐ No

Has your child had a history of:

- Blood Disease ☐ Yes ☐ No
- Rheumatic Fever ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Lung Disease ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Excessive Bleeding ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- ADHD/ADD ☐ Yes ☐ No
- Autism ☐ Yes ☐ No
- Leukemia ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Heart Disease ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Cold Sores ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- Recurrent Colds ☐ Yes ☐ No
- Emotional Problems ☐ Yes ☐ No
- Epilepsy ☐ Yes ☐ No
- Mental or Physical Handicaps ☐ Yes ☐ No
- Toothaches ☐ Yes ☐ No
- HIV/AIDS ☐ Yes ☐ No

Other ______________________

Remarks/Explain ______________________

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ALLERGIES

☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Other ______________________

SIGNATURE

Signature (Parent's signature if minor) ______________________

Updates/Comments ______________________

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