
**Today's Date**: _____

**Patient's Name**: _____ Gender: _____

**Patient Date of Birth**: _____

**If Child, Parent's Name:** _____

**How you wish to be addressed**: _____

**Address**: _____

**City**: _____ **State**: _____ **Zip Code**: _____

**Home Phone Number**: _____

**Cell Phone Number**: _____

**Email Address**: _____

**Employer**: _____

**Position**: _____

**Spouse Name**: _____

**Spouse Employer**: _____

**Position**: _____

**Who is responsible for this account?** _____

**Purpose of first visit**: _____

**Other Family Members in this practice**: _____

**Whom may we thank for this referral:** _____

**Emergency Contact Name:** _____

**Emergency Contact Phone Number:** _____

**CONSENT:** I consent to the diagnostic procedures and treatment necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of my records shall be effective until I revoke it in writing. I attest to the accuracy of the information on this page.

**Patient or Guardian Signature**: _____ **Date:** _____


**Our practice is not affiliated with any dental or medical insurance plans as a preferred provider. As a result, we ask for payment at the time services are rendered. We will be happy to assist by providing our patients with information to furnish their insurance companies for potential reimbursement.**

**Medical Insurance**

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

**Dental Insurance**

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

# Child New Patient Medical Background Information

## PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Parent or Guardian's Name: _____

Chief Complaint or Concern:

_____

_____

_____

## MEDICATIONS (including prescription and over the counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Does your child have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

## PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Has your child ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

## ALLERGY HISTORY

❑None Known ❑ Yes, to: 1._____ 3._____

2._____ 4._____

**Pets: ❑ No ❑ Yes How many? _____ What type of pet**? _____

**Do any pets sleep in your child's bedroom? ❑ No ❑ Yes**

**Which pets?** _____

## FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

| | | |
|---|---|---|
| ❑ High blood pressure/hypertension | ❑ Diabetes | ❑ Chronic insomnia |
| ❑ Heart disease | ❑ Overweight/obesity | ❑ Restless legs syndrome |
| ❑ Stroke | ❑ Snoring | ❑ Multiple sclerosis |
| ❑ Congestive heart failure | ❑ Sleep apnea | ❑ Sleep walking |
| ❑ Depression | ❑ Anxiety | |

## REVIEW OF SYMPTOMS

**Constitutional:**

| | |
|---|---|
| Loss of Appetite: | ❑ Yes ❑ No |
| Fever: | ❑ Yes ❑ No |
| Fatigue: | ❑ Yes ❑ No |
| Weight Gain: | ❑ Yes ❑ No |
| Weight Loss: | ❑ Yes ❑ No |

**Respiratory:**

| | |
|---|---|
| Cough: | ❑ Yes ❑ No |
| Asthma: | ❑ Yes ❑ No |
| Wheezing: | ❑ Yes ❑ No |
| Poor Exercise Tolerance: | ❑ Yes ❑ No |

## REVIEW OF SYMPTOMS

**Gastrointestinal:**

Heartburn/Indigestion: ❑ Yes ❑ No

Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No

Nausea/Vomiting: ❑ Yes ❑ No

Jaundice: ❑ Yes ❑ No

Abdominal Pain ❑ Yes ❑ No

**Allergy/Immunology:**

Nasal allergies/Hay fever/

Nasal Congestion**:** ❑ Yes ❑ No

Sneezing**:** ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Itchy Eyes or Nose: ❑ Yes ❑ No

Hives: ❑ Yes ❑ No

**Eyes:**

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss : ❑ Yes ❑ No

**Genitourinary:**

Frequent Urination ❑ Yes ❑ No

Difficulty Urinating: ❑ Yes ❑ No

Blood in Urine: ❑ Yes ❑ No

**Musculoskeletal:**

Stiff/Sore Joints: ❑ Yes ❑ No

Muscle Pain: ❑ Yes ❑ No

Red or Swollen Joints: ❑ Yes ❑ No

Temporomandibular Joint

(TMJ) pain/jaw discomfort: ❑ Yes ❑ No

**Ears/Nose/Throat/Mouth:**

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

Tubes in Ears: ❑ Yes ❑ No

## REVIEW OF SYMPTOMS

**Cardiac:**

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Hypertension/High Blood Pressure ❑ Yes ❑No

**Skin:**

Unusual Moles: ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

**Endocrine:**

Heat Intolerance ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ Yes ❑ No

**Neurologic:**

Weakness: ❑ Yes ❑ No

Seizures: ❑ Yes ❑ No

Involuntary Tongue Biting: ❑ Yes ❑ No

Passing Out: ❑ Yes ❑ No

Dizziness: ❑ Yes ❑ No

Headaches: ❑ Yes ❑ No

Numbness: ❑ Yes ❑ No

**Psychiatric:**

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

**Was your child breast fed? ❑ Yes ❑ No**

**If your child was breast fed – for how long? _____**

**Was your child ❑ Full Term ❑ Premature**

**If Premature – at how many weeks was your child delivered? _____**

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION**

**Patient Name:**_____ **Date of Birth:**_____/_____ /_____

1. Reason for today's visit: _____
2. Are you aware of any problems? _____
3. How long since your last dental visit? _____
4. What was done at that time?_____
5. Previous Dentist's Name: _____
6. When was the last time your teeth were cleaned?_____

**COMMENTS: OFFICE USE ONLY**

**CIRCLE THE APPROPIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE.**

7. Have you made regular dental visits?_____ ☐YES ☐NO
8. Were dental x-rays taken?_____ ☐YES ☐NO
9. Have you lost any teeth or have any teeth been removed?___ ☐YES ☐NO
    a. Why? _____
10. Have they been replaced?_____ ☐YES ☐NO
11. How have they been replaced?_____ ☐YES ☐NO
    a. Fixed Bridges_____When? _____
    b. Removable Bridge_____When? _____
    c. Denture_____When? _____
    d. Implant_____ When?_____
12. Are you happy with the replacement?_____ ☐YES ☐NO
    a. If not, please explain_____
13. Would you like to know about permanent replacement?____ ☐YES ☐NO
14. Have you ever had any problems or complications with previous dental treatment?_____ ☐YES ☐NO
15. Do you clench or grind your teeth?_____ ☐YES ☐NO
16. Does your jaw pop or click? _____ ☐YES ☐NO
17. Have you experienced any pain or soreness in the muscles in your face or around your ear? _____ ☐YES ☐NO
18. Do you have frequent headaches,neckaches,shoulder aches? ☐YES ☐NO
19. Does your food get caught in your teeth?_____ ☐YES ☐NO
20. Are any of your teeth sensitive to ☐HOT ☐COLD ☐SWEETS ☐PRESSURE?
21. Do your gums bleed or hurt? _____ ☐YES ☐NO
22. Have you ever had gum treatment or surgery? _____ ☐YES ☐NO
    a. What? _____
    b. Where? _____
    c. When?_____
23. Do you feel your breath is offensive at times? _____ ☐YES ☐NO
24. How often do you brush your teeth daily? _____ ☐YES ☐NO
25. Do you use dental floss? _____ ☐YES ☐NO
    a. How often? _____
26. Are any of your teeth: ☐LOOSE? ☐TIPPED? ☐SHIFTED? ☐CHIPPED?
27. Are you happy with the appearance of your teeth?_____ ☐YES ☐NO
28. How do you feel about your teeth in general?_____
29. Have you had orthodontic work?_____ ☐YES ☐NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
31. Do you have any questions or concerns?_____ ☐YES ☐NO

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

**PATIENT'S/GUARDIN'S SIGNATURE _____**

**DENTIST'S SIGNATIURE _____**

Patient Form

healthystart®

Doctor / Dentist: _____

Patient's Name: _____ DOB: _____ Age: _____

Relationship to Patient: _____ Pediatrician: _____

# Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dates at first appointment and the follow-up score column should be evaluated and dated after 3 months of treatment by the same person who filled out the initial assessment.

Date of Initial Assessment: _____ Date of Follow-up Assessment: _____

Filled Out By: _____ Filled Out By: _____

**Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5**

| | INITAL SCORE | FOLLOW-UP SCORE | |
|---|---|---|---|
| 1. | | | Snoring of any kind |
| 2. | | | Snores only infrequently (1 night/week) |
| 3. | | | Snores fairly often (2-4 nights/week) |
| 4. | | | Snores habitually (5-7 nights/week) |
| 5. | | | Has labored, difficult, loud breathing at night |
| 6. | | | Has interrupted snoring where breathing stops for 4 or more seconds |
| 7. | | | Had 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<br>☐ Food allergies ☐ Asthma<br>☐ Eczema ☐ Nasal Congestion<br>☐ Seasonal ☐ Animal ☐ Other: |
| 13. | | | Excessive sweating while asleep |
| 14. | | | Talks or walks in sleep |
| 15. | | | Poor ability in school*<br>☐ Math ☐ Science<br>☐ Spelling ☐ Reading<br>☐ Writing ☐ Behavior Problems |
| 16. | | | Falls asleep watching TV or at school |
| 17. | | | Wakes up at night |
| 18. | | | Attention deficit |
| 19. | | | Restless Sleep |
| 20. | | | Grinds Teeth |
| 21. | | | Frequent throat or other infections |
| 22. | | | Frequent ear infections |
| 23. | | | Feels sleepy and/or irritable during the day |
| 24. | | | Has a difficult time listening and often interupts |
| 25. | | | Fidgets with hands or does not sit quietly*<br>☐ Nervous muscular tics<br>☐ Restless (wiggles) legs |
| 26. | | | Ever wets the bed |
| 27. | | | Exhibits bluish color at night or during the day or under eyes |
| 28. | | | Nightmares and/or night terrors |
| 29. | | | Exhibits any of the following*:<br>☐ Rarely smiles<br>☐ Feels sad<br>☐ Feels depressed |
| 30. | | | Speech problems** |
| 31. | | | Nasal breathing difficult<br>☐ Normal nasal breathing<br>☐ Can't breathe through nose |
| 32. | | | Resists routines and directions |

*Please indicate with a X if condition is present

** If scored greater than 0, please continue to Speech Questionnaire on page 2 (reverse side)Please indicate with a X if condition is present

Revised 12/2020

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

Patient Form

Continued from question #30 on reverse side

healthystart®

# Speech Questionnaire for Children

Earl O. Bergersen, DDS, MSD

Not Present: 0 | Very Mild: 1 | Mild: 2 | Moderate: 3 | Pronounced: 4 | Severe: 5

## Speech Assessment

| | INITIAL SCORE | FOLLOW-UP SCORE | |
|---|---|---|---|
| 33. | _____ | _____ | Do you or do others have difficulty understand your child's speech? |
| 34. | _____ | _____ | Difficult to understand over the phone |
| 35. | _____ | _____ | Uses grunts or screams more than words |
| 36. | _____ | _____ | Lisp |
| 37. | _____ | _____ | Hoarseness |
| 38. | _____ | _____ | Nasal speech |
| 39. | _____ | _____ | Becomes frustrated when attempting to speak |
| 40. | _____ | _____ | Often uses words with only 1 or 2 syllables |
| 41. | _____ | _____ | Seems winded when increasing volume |
| 42. | _____ | _____ | Any difficulty in swallowing |
| 43. | _____ | _____ | Stutters<br>Any family history of a stutter?<br>☐ Yes ☐ No |
| 44. | _____ | _____ | Tourette's Syndrome |
| 45. | _____ | _____ | Family history of a speech or language disorder |
| 46. | _____ | _____ | Any speech therapy?<br>If so, how long? _____ |

## Specific Articulation Questions

| | INITIAL SCORE | FOLLOW-UP SCORE | |
|---|---|---|---|
| 47. | _____ | _____ | Child replaces a "t, d, n, s, z, th or l" with a "p, b, m, w, f, or v"<br>Example: "hap" for "hat", "kif" for "kiss", "fum" for "thumb", or "bav" for "bath" |
| 48. | _____ | _____ | Child replaces an "r" with a "w" or an "L" with a "w" or a "y"<br>Example: "wabbit" for "rabbit", "yewo" for yellow" "weg" for "leg", "pway" for "play", "wun, for "run" |
| 49. | _____ | _____ | Child replaces a "s, f, v, z, th, j, or h" with a consonant such as "p, b, t, d, k, g"<br>Example: "tock" for "sock", "dump" for "jump", "pan" for fan", "bat" for "fat" |
| 50. | _____ | _____ | Child replaces a "p, b, m, w, th, f, or v" with a "t, d, s, z, n, or l"<br>Example: "sum" for "thumb", "muhzer" for "mother" |
| 51. | _____ | _____ | Child replaces a "t" or a "d" with "k" or "g"<br>Example: "gog" for "dog", "cop" for "top", "boke" for "boat", "key" for "tea" |
| 52. | _____ | _____ | Child replaces a "ch" or a "j" sound with a "sh, v, f, th, or s"<br>Example: "ship" for "chip", "shoo shoo" for "choo choo" |
| 53. | _____ | _____ | Child changes position of a sound within a word<br>Example: "pasghetti" for "spaghetti", "efelant" for "elephant", "baksit" for "basket" |
| 54. | _____ | _____ | Child inserts "uh" into words<br>Example: "stuh-reet" for "street", "fuh-wog" for "frog", "buh-lue" for "blue", "puh-lease" for "please" |
| 55. | _____ | _____ | Child replaces a "k" or a "g" with "t" or "d"<br>Example: "doat" for "goat", "tuhtie" for "cookie", "tup" for "cup", "hud" for "hug" |
| 56. | _____ | _____ | Child replaces a "sh" with an "s"<br>Example: "sue" for "shoe", "sip" for "ship", "mezza" for "measure" |





Revised 12/2019