Patient name: Last First MI Birthdate Dental Chart#

Home Address Sex Male Female VC #

City State Zip Telephone (Home) Soc. Sec. #

Parent or Legal Guardian: If No Phone, Where You Can Be Reached
Last First MI

Work Address

City State Zip Telephone (Work)

DENTAL INSURANCE INFORMATION

Medicaid# Benefit Year Insurance Name Group#

PEDIATRIC MEDICAL HISTORY

Please circle the appropriate answer

1. Does your child have a health problem?.....Yes No
2. Was your child a patient in a hospital?.....Yes No
3. Date of last physical exam_____
4. Is your child under medical care?.....Yes No
5. Is your child taking medication now?.....Yes No
   If so, for what?_____
6. Has your child ever had a serious illness or operation?....Yes No
7. If so, explain_____
8. Are your child's immunizations up to date?.....Yes No
   Date of last tetanus shot_____
9. Does you child have (or ever had) any of the following diseases?
   a. Rheumatic fever or rheumatic heart disease.....Yes No
   b. Congenital heart disease.....Yes No
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....Yes No
   d. Allergy? Food [ ] Medicine [ ] Other [ ]....Yes No
   e. Asthma [ ] Hay Fever [ ].....Yes No
   f. Hives or a skin rash.....Yes No
   g. Fainting spells or seizures.....Yes No
   h. Hepatitis, jaundice or liver disease.....Yes No
   i. Diabetes.....Yes No
   j. Inflammatory rheumatism(painful or swollen joints)Yes No
   k. Arthritis.....Yes No
   l. Stomach ulcers.....Yes No
   m. Kidney trouble.....Yes No
   n. Tuberculosis (TB).....Yes No
   o. Persistent cough or cough up blood.....Yes No
   p. Venereal disease.....Yes No
   q. Epilepsy.....Yes No
   r. Sickle Cell disease.....Yes No
   s. Thyroid disease.....Yes No
   t. HIV.....Yes No
   u. Emphysema.....Yes No
   v. Psychiatric treatment.....Yes No
   w. Cleft lip/palate.....Yes No
   x. Cerebral Palsy.....Yes No
   y. Mental retardation.....Yes No
   z. Hearing disability.....Yes No
   aa. Developmental disability.....Yes No
   If yes, explain:_____
   bb. Was your child premature?.....Yes No
   If yes, how many weeks_____
   cc. Other:_____
10. Does your child have to urinate (pass water) more than six times a day?.....Yes No
11. Is your child thirsty much of the time?.....Yes No
12. Has your child had abnormal bleeding associated with previous surgery or accidents?.....Yes No
13. Does he/she bruise easily?..... Yes No
14. Has he/she ever required a blood transfusion?.....Yes No
15. Does he /she have any blood disorders such as anemia, etc.?.....Yes No
16. Has he/she ever had surgery, x-ray or chemotherapy for a tumor, growth, or other condition?.....Yes No
17. Does your child have a disability that prevents treatment in a dental office?.....Yes No
18. Is he/she taking any of the following?
   a. Antibiotics or sulfa drugs.....Yes No
   b. Anticoagulants (blood thinners).....Yes No
   c. Medicine for high blood pressure.....Yes No
   d. Cortisone or steroids.....Yes No
   e. Tranquilizers.....Yes No
   f. Aspirin.....Yes No
   g. Dilantin or other anticonvulsant.....Yes No
   h. Insulin, tolbutamide, Orinase, or similar drug.....Yes No
   i. Any other?_____
19. Is he/she allergic to, or has he/she ever reacted adversely to any of the following?
   a. Local anesthetics(Novocaine).....Yes No
   b. Penicillin or other antibiotics.....Yes No
   c. Sulfa drugs.....Yes No
   d. Barbiturates, sedatives, or sleeping pills.....Yes No
   e. Aspirin.....Yes No
   f. Any other drugs?_____
20. Has he/she had any serious trouble associated with any previous dental treatment?.....Yes No
21. Does your child have any other disorder that has not been mentioned?.....Yes No
   If so, please explain:_____
22. Has your child been in any situation which could have exposed him/her to x-rays or other ionizing radiation?.....Yes No
23. Last date of dental examination:_____
24. Has he/she ever had orthodontic treatment(worn braces)?Yes No
25. Has he/she ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)?.....Yes No
26. Does his/her gums bleed when brushing teeth?.....Yes No
27. Does he/she grind or clench teeth?.....Yes No
28. Has he/she often had toothaches?.....Yes No
29. Has he/she had frequent sores in his/her mouth?.....Yes No
30. Has he/she had any injuries to his/her mouth or jaws?.....Yes No
   If yes, explain:_____
31. Does he/she have any sores or swellings of his/her mouth or jaws?.....Yes No
32. Have you been satisfied with your child's previous dental care?.....Yes No

ADOLESCENT WOMEN:

33. Are you pregnant now, or think you may be?.....Yes No
34. Do you anticipate becoming pregnant?.....Yes No
35. Are you taking birth control pills?.....Yes No

TURN OVER AND COMPLETE OTHER SIDE

COLUMBIA UNIVERSITY SCHOOL OF DENTAL AND ORAL SURGERY
PEDIATRIC DENTAL ORAL EXAMINATION

VC#_____
Dental Chart #_____
Medicaid#_____

NAME_____

MEDICAL ALERT

CHIEF ORAL COMPLAINT:

PREVIOUS DENTAL HX:

MEDICAL HISTORY SUMMARY:

ALLERGIES:

MEDICATIONS:

PROPHYLACTIC ANTIBIOTICS RECOMMENDED:

LYMPH NODES:	SALIVARY GLANDS:
ORO-PHARYNX:	PALATE:
LIPS:	BUCCAL MUCOSA
TONGUE:	FLOOR OF MOUTH
ORAL HYGIENE:	CALCULUS
CARIES:	GINGIVA

STAIN: HYPOPLASIA: DECALCIFICATION: HYPOCALCIFICATION:

HABITS: THUMB___ FINGER___ TONGUE___ BRUXISM___ OTHER:

BEHAVIOR (FRANKL SCALE 1 = VERY POOR. 4 = EXCELLENT):

SPECIAL MGT: PAPOOSE N.O CONSCIOUS SED. KETAMINE SED. G.A. OTHER:

PROFILE: BIMAX._____ ORTHO_____ PROG_____ RETRO_____

PRIMATE SPACING: MAXILLARY R___ L___ MANDIBULAR R___ L___

ANGLE'S CLASS : NEUTRO___ I___ II___ DIV 1___ DIV 2___ III___

TERMINAL PLANE R: M___ D___ F___ L: M___ D___ F___

ARCH SYMMETRY:

MIDLINE: SPACING:

CROWDING: MAX.: MILD___ MOD.___ SEVERE___ Ant.___ Post.___

MAND.: MILD MOD. SEVERE Ant. Post.

CROSSBITE: ANT POST. BILAT UNIL. L R

OVERBITE % OVERJET mm OPENBITE mm

Dietary Analysis Indicated Yes ☐ No ☐

Diet History Returned _____ Date Diet Analysis Performed _____ Date

Results of Diet Analysis:

Home Fluoride Rx: TABS___ DROPS___ RINSES___ TRAYS___

EXAMINER'S SIGNATURE:_____ DATE:_____

DATE:

PLAQUE INDEX

DATE				
# 3 or #A Buccal				
#8 or #E Buccal				
#14 or #J Buccal				
#19 or #K Buccal				
#24 or #O Buccal				
#30 or #T Lingual				
Total				

SCORING SYSTEM

0 No Plaque

1 Slight amount of Plaque

2 Large amount of Plaque

0-4 Good Oral Hygiene

4-8 Fair Oral Hygien

8-12 Poor Oral Hygiene

Columbia University
School of Dental and Oral Surgery
630 West 168th Street
New York, N.Y. 10032

Date:_____
VC Chart#_____ Dental Chart#_____
Patient Name:_____
Date of Birth:_____

PEDIATRIC DENTISTRY
CONSENT TO DENTAL PROCEDURE
AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

STATE LAW REQUIRES US TO OBTAIN YOUR CONSENT FOR YOUR CHILD'S CONTEMPLATED DENTAL TREATMENT OR ORAL SURGERY. PLEAS READ THIS FORM CAREFULLY AND ASK ABOUT ANYTHING YOU DO NOT UNDERSTAND. WE WILL BE PLEASED TO EXPLAIN.

I HEREBY AUTHORIZE CONSENT FOR ORAL AND DENTAL RADIOGRAPHIC (X-RAY) EXAMINATION AND DIAGNOSIS, DENTAL PROPHYLAXIS (CLEANING) AND TOPICAL FLUORIDE TREATMENT TO BE PERFORMED UPON_____, MY CHILD (OR LEGAL WARD) FOR WHOM I AM EMPOWERED TO CONSENT.

I FURTHER CONSENT TO EMERGENCY TREATMENT FOR _____
CONDITION

WHICH I UNDERSTAND WILL INCLUDE THE FOLLOWING:

_____ _____
PARENT OR LEGAL GUARDIAN DATE WITNESS DATE

INFORMED CONSENT FOR SPECIFIC PROCEDURES

I HEREBY AUTHORIZE AND DIRECT THE FACULTY AND PROFESSIONAL DENTAL STAFF OF COLUMBIA UNIVERSITY SCHOOL OF DENTAL AND ORAL SURGERY AND COLUMBIA-PRESBYTERIAN MEDICAL CENTER ASSISTED BY STUDENT DENTISTS, RESIDENTS, AND/OR DENTAL AUXILIARIES OF THEIR CHOICE TO PERFORM UPON _____, MY CHILD (OR LEGAL WARD) THE FOLLOWING DENTAL TREATMENT OR ORAL SURGERY PROCEDURES:
INITIAL (SIGNIFY APPROVAL BY INITIALING IN THE SPACE PROVIDED)

_____[ ] A. APPLICATION OF SEALANTS TO THE GROOVES OF THE TEETH
_____[ ] B. USE OF LOCAL ANESTHESIA TO NUMB THE TEETH AND TISSUES
_____[ ] C. TREATMENT OF DISEASED OR INJURED TEETH WITH DENTAL RESTORATIONS (FILLINGS)
COMPOSITE RESIN_____AMALGAM_____STAINLESS STEEL CROWNS_____
PULP TREATMENTS_____OTHER_____
_____[ ] D. TREATMENT OF INJURED OR INFECTED PULPS (NERVES) OF TEETH
_____[ ] E. REMOVAL (EXTRACTION) OF TEETH-- PRIMARY(BABY)_____PERMANENT_____
_____[ ] F. REPLACEMENT OF MISSING TEETH WITH DENTAL PROSTHESIS
_____[ ] G. TREATMENT OF DISEASED OR INJURED ORAL TISSUES (HARD AND SOFT)
_____[ ] H. TREATMENT OF MALPOSED (CROOKED) TEETH AND/OR ORAL DEVELOPMENTAL OR GROWTH ABNORMALITIES:_____
specify condition and treatment
_____[ ] I. THE USE OF PHYSICAL RESTRAINT OR RESTRAINING DEVICES TO SAFELY ACCOMPLISH THE NECESSARY DENTAL PROCEDURES. TYPE OF RESTRAINT:_____

Columbia University
School of Dental & Oral Surgery

TRAUMA TREATMENT FORM

Patient's Name _____ Date of Birth _____

Date of Examination _____ Age _____

Medical Alert _____

History of Injury:

Date & Time of Injury _____ time elapsed since injury _____

Place of Injury _____

How injury occurred _____

_____

Previous history of injury: Yes _____ No _____

Describe: _____

Details of Examination:

Soft Tissue Observation:

Laceration :	Lip ____	Gingivae ____	None ____
Ecchymosis:	Lip ____	Gingivae ____	None ____
Swelling:	Lip ____	Gingivae ____	None ____

Describe:

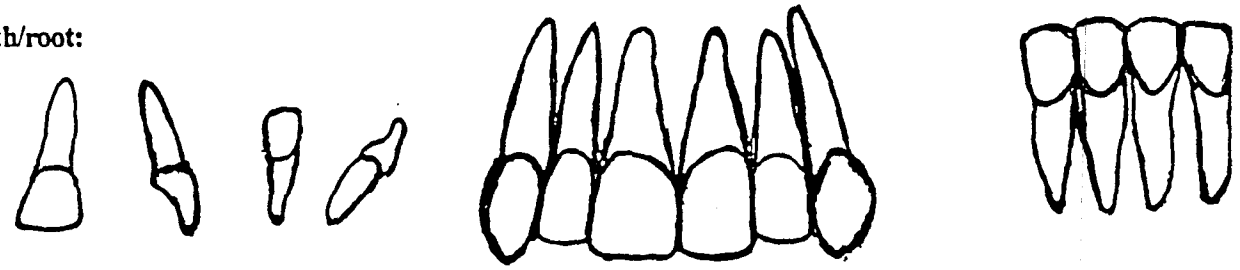
_____

Occlusion (Angle classif.) _____ Overjet _____ mm Overbite _____ %

Mobility/Avulsion _____ Displacement _____

Fracture _____ Color _____

Draw injury on tooth/root:



Pulp exposed: Yes ____ No ____ Size of Exposure _____

Adjacent and opposing teeth: (describe if injured) _____

_____

Radiographic Data:

Pulp size: Large _____ Average _____ Small _____

Evidence of calcific degeneration: Yes ____ No ____

Root development: 1/3 ____ 1/2 ____ 2/3 ____ Complete _____

Periapical pathology: Yes ____ No ____

Internal/External Resorption: _____

(over)

MIXED DENTITION ANALYSIS

Mandibular Incisor Sizes				
Total	2 (26)	1 (25)	1 (24)	2 (23)

3,4,5 @ 75% = (Perm. Cuspid and Bicuspids) — * — Predicted Upper Posterior Space Required

3,4,5 @ 75% = — ** — Predicted Lower Posterior Space Required

(UPPER) PROBABILITY CHART FOR PREDICTING THE SUM OF THE WIDTHS OF 345 FROM $\overline{21/12}$

$\Sigma\overline{21/12}$ =	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0
75%	20.6	20.9	21.2	21.5	21.8	22.0	22.3	22.6	22.9	23.1	23.4	23.7	24.0	24.2	24.5	24.8	25.0	25.3	25.6	25.9

(LOWER) PROBABILITY CHART FOR PREDICTING THE SUM OF THE WIDTHS OF $\overline{345}$ FROM $\overline{21/12}$

$\Sigma\overline{21/12}$ =	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0
75%	20.1	20.4	20.7	21.0	21.3	21.6	21.9	22.2	22.5	22.8	23.1	23.4	23.7	24.0	24.3	24.6	24.8	25.1	25.4	25.7

MAXILLA

Anterior Space Required	
Space Available	
Difference ±	

Space Required*			Space Required*
Space Available			Space Available
Difference ±			± Difference
Right			Left

Maxillary Total Space Required	
Maxillary Total Space Available	
Maxillary Difference ±	

MANDIBLE

Mandibular Total Space Required	
Mandibular Total Space Available	
Mandibular Difference ±	

Right			Left
Space Required**			Space Required**
Space Available			Space Available
Difference ±			± Difference

	Ant. Space Required
	Space Available
	± Difference

Total Space Required: Total space required for measured or predicted size of unerupted permanent teeth

Total Space Available: Total arch length or the space available from the mesial of the right first permanent molar to the mesial of the left first permanent molar.