University of Minnesota, School of Dentistry
Ralph B. Kersten Palate/Craniofacial Clinics
Admissions Questionnaire

We appreciate your efforts to answer the following questions as completely and accurately as possible:

Child's name:_____ **Sex:**_____ **Date of Birth:**_____
Address:_____ **Date Today:**_____
_____ **Phone:** _____
Does child live with parents? ____ yes ____no. If not, name of person with whom child lives:
_____
Do you consider your child to be Hispanic or Latino ethnicity? ____ yes ____no
Please circle the race or races best describing your child:

Black or African American
Native Hawaiian or other Pacific Islander
Asian
American Indian or Alaska Native
White
Other _____
Unknown

Information on race or ethnicity is optional and is collected to help describe the diversity of the patients we serve.

Parental Information:

Mother	**Father**
Name:_____	_____
Age: _____	_____
Address:_____	_____
(please write "same" if same as child)	
Occupation: _____	_____
Business Phone: _____	_____
Business Address: _____	_____
Education: _____	_____

(please enter highest school grade completed-high school, vocational/college/university degree(s))

Names of other children in family	**Sex**	**Age**	**School Placement**

Name of person who referred you to our Cleft Palate/Craniofacial Clinic:
_____ **Phone:** _____
Address: _____

Medical/Developmental History

Child's Birth weight: _____ Length: _____ Born (hospital/city):_____
Medications used during pregnancy: _____
Complications during pregnancy (premature labor, bleeding, etc.)

Was your child born premature; if so, how early? _____
As an infant, was your child fed by breast or bottle? _____

Did your child have difficulty sucking, swallowing, and/or gaining weight? _____

Does your child's have a cleft lip? _____Cleft Palate?_____Both?_____

How would you describe your child's general health? _____
Has your child been hospitalized for any illness (other than surgery)?

Has your child required treatment for any chronic illness (such as diabetes, epilepsy, heart condition)?

Have you been told your child has a specific syndrome or condition other then cleft lip or palate?

If yes, who diagnosed this syndrome or condition? _____ When? _____
Were you given information about the chance of this happening to your other children or your children's children? (e.g. by your doctor or a genetic counselor)?

Is there a family history of clefts, birth defects, heart defects, speech or hearing difficulties?

Please list any medications your child takes on a regular basis:

Please list any allergies your child had to medications/food/environment:

Have you had concerns about your child's growth and development?

Does your child snore, or have any difficulty sleeping?

Does your child have any difficulty chewing or swallowing? _____
Does your child have mobility limitations? (i.e., wheelchair, walker, etc.)

Please list your child's surgeries:
Date (or approximate) Name of Surgery Surgeon/Location

_____
_____
_____
_____

Speech and Education History

Do you think your child has a speech problem? _____ yes _____ no
Do you think your child has a hearing problem? _____ yes _____ no
Has your child been seen by anyone for a speech or hearing problem? _____
_____
_____
_____
_____

Is your child receiving speech and/or language treatment now? _____ yes _____no
Has your child received other special services in school (special education support, occupational therapy, physical therapy, etc.)?

_____
Is he/she currently receiving these services? _____
Name, phone and address of school child is attending:

Insurance Information

How will clinic fees be paid?
Self _____ Insurance (specify) _____ Other (specify) _____
Important: If fees are to be paid by insurance, please provide all information requested in the enclosed Patient Information Registration form.
If participating in Medical Assistance, please indicate MA number:

_____
Name of caseworker or social worker: _____County: _____
If this patient has been seen in the Fairview University Hospitals or Clinics, please indicate the identification number: _____

Do you have any suggestions as to what we might do to make your child's visit to this clinic a pleasant one?
_____
_____
_____
_____
_____
_____
_____

Please see the next page before finishing. Thank you for taking the time to share this information with us!

Health Care Providers (Complete names and addresses are very helpful in coordinating care for your child).

Primary Care Physician: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

Plastic or Pediatric Surgeon: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

Oral Maxillofacial Surgeon:
_____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

Ear, Nose, and Throat: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

Dentist: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

Orthodontist: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

Speech Therapist: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____

OTHERS: (i.e., audiologist, orthopedist, occupational or physical therapist, neurologist, geneticist, ophthalmologist, neurosurgeon, psychologist, etc.)
Name: _____
Address: _____
Phone: _____
When last seen: _____ **Reason:** _____