

Patient Medical History



GENERAL

Child's Name: _____

Describe the primary concern with your child's teeth:

Has your child had any unfavorable reactions to past dental treatment?

If so, please explain:

What things does your child enjoy?: _____

DENTAL

Does/Is your Child:

- Yes No Take Fluoride Supplements
- Yes No Use a pacifier, suck thumb/finger/lip, bite lip If so, please circle answer
- Yes No Bite or chew nails
- Yes No Grind teeth/clench Jaws/have TMJ pain? If so, please circle answer
- Yes No Gag easily
- Yes No Brush daily If so, how often? ____ Floss daily? Yes No If so, how often? ____
- Yes No Breastfed Age discontinued ____
- Yes No Bottledfed Age discontinued ____
- Yes No Require Antibiotics for dental work?
- Yes No Need dental work completed (referred from another dentist or you feel they do)
- Yes No Presently in dental pain?
- Yes No Have any extra, missing, or extracted teeth? If so, please circle answer
- Yes No Have a history/present today with trauma to the head, face, or teeth? which one?
- Yes No Have any other habits not listed above? If yes please specify _____

MEDICAL

Please check any problems or conditions that may apply to your child & circle exact answer

- Asthma/Respiratory problems Epilepsy/Seizures Mental Disorder
- Autism/ADD/ADHD Endocrine Rheumatic Fever
- Brain Injury Gastrointestinal/Kidney Speech Delay
- Bleeding disorder/Delay/Anemia Heart Murmur Transfusion
- Cancer Hepatitis/Liver/Infectious Dis Tuberculosis
- Cerebral Palsy/CNS problem Herpes/Fever Blisters Vision Disorder
- Congenital Heart Defect/Problem Immunizations up to date My child is healthy
- Diabetes Lung Problems Developmental Delay
- Drug/Alcohol Abuse
- Other: _____

If you said yes to any of the above, please explain: _____

Current medications & dosages taken: _____

Allergies or adverse reactions to any medications (e.g. penicillin/sulfas) _____

Allergies to any substances (e.g. latex) _____

Previous hospitalizations, surgeries, or serious illnesses, and date _____

Has your child had any abnormal bleeding associated with previous extractions, surgery, or trauma? (If yes, please explain) _____

Date of last dental visit _____ Previous Dentist _____

Child's Pediatrician: _____ Phone Number _____

Is there anything else you would like us to be aware of regarding your child? _____

Authorization and Release To the best of my knowledge, the question on this form have been accurately answered.

I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and /or other health practitioners as necessary. May we request release of your child's medical and dental records? _____

With your verbal permission, you agree to release your child's records to another doctor at their/your request

Signature of Parent/Guardian X _____ Date: _____