Your Child's Medical History

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

Abnormal bleeding	☐ yes	☐ no
AIDS/HIV positive	☐ yes	☐ no
Allergies or hives	☐ yes	☐ no
Anemia	☐ yes	☐ no
Asthma	☐ yes	☐ no
Cancer	☐ yes	☐ no
Chicken pox	☐ yes	☐ no
Congenital heart disease	☐ yes	☐ no
Convulsions	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Epilepsy	☐ yes	☐ no
Handicaps / disabilities	☐ yes	☐ no
Hay fever	☐ yes	☐ no
Hearing problems	☐ yes	☐ no
Heart murmur	☐ yes	☐ no
Hemophilia	☐ yes	☐ no
Hepatitis	☐ yes	☐ no
Kidney / liver problems	☐ yes	☐ no
Latex sensitivity	☐ yes	☐ no
Measles	☐ yes	☐ no
Mononucleosis	☐ yes	☐ no
Mumps	☐ yes	☐ no
Neurological disorders	☐ yes	☐ no
Psychiatric / psychological	☐ yes	☐ no
Rheumatic / scarlet fever	☐ yes	☐ no
Stomach problems	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no

Other? ☐ yes ☐ no Please specify:

_____

_____

Your Child's Physician: _____

City: _____

Phone: _____

Is your child under the care of a physician? Y N

If yes, please describe _____

_____

Is your child taking any medications? Y N
(prescription or over-the-counter)

If yes, please describe _____

_____

Have you ever been told your child needs antibiotics or pre-medication before treatment? Y N

If yes, please list _____

_____

Does your child have any allergic (or adverse) reaction to any medication or substance? Y N

If yes, please list _____

_____

Are your child's immunizations current? Y N

List any hospitalizations, surgeries, serious illnesses:

_____ When _____

_____ When _____

I have read and understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all the questions accurately to the best of my knowledge. I understand it is my responsibility to inform the dentist of any changes in medical status. I authorize the dental office to administer any necessary treatment needed for proper dental care. I authorize payment to the dental office for services rendered, and understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the dentist to release dental/medical histories and other information about dental treatment to third party payers and/or other health professionals.

Patient/Guardian Signature _____ Date _____

OFFICE USE - REVIEW

UPDATES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Your Child

Child's Name_____

Nickname_____ M ( ) F ( )

Child's Birthdate_____/_____/_____Age_____

Child's Address_____

City _____ State _____ Zip _____

Home phone # _____

Who is accompanying the child:

Name _____

Relationship _____ Legal Custody? Yes ( ) No ( )

Parent email _____

Other family seen by us _____

Parent's marital status: S M W D SEP

Mother's name: _____

Address _____

City _____ State _____ Zip _____

Hm #_____Wk # _____

Cell # _____

Employer _____

SS # _____

Father's name: _____

Address _____

City _____ State _____ Zip _____

Hm #_____Wk # _____

Cell # _____

Employer _____

SS # _____

Dental History

What is the reason for your visit today?

_____

Any problems with previous dental work?

_____

Dental health:	Good	Fair	Poor
Is the child in pain?		Y	N
Is child's water fluoridated?		Y	N
Taking fluoride supplements?		Y	N
Does the child brush daily?		Y	N
Floss their teeth daily?		Y	N
Do your child's gums bleed or hurt?		Y	N

Has your child ever worn orthodontic appliances? Y N

Describe: _____

Does your child engage in:

Y N Thumb / finger sucking
Y N Lip sucking / biting
Y N Nail biting
Y N Chewing hard objects
Y N Nursing bottle habits
Y N Grinding teeth
Y N Mouth breathing
Y N Clenching jaw

Do you have any special concerns about your child's dental health? Y N

Describe: _____

_____

Who may we thank for referring you?

_____

PLEASE LIST A CONTACT OTHER THAN IMMEDIATE FAMILY

Name _____

Relationship _____

Home # _____Cell # _____

Work # _____Ext. _____

OVER PLEASE - - - - - - - - - - ➤