PATIENT INFORMATION AND HEALTH HISTORY

Child's Name:_____Nickname:_____Age:_____Date of Birth:_____ Sex: M / F
Permanent Addresss:_____
City:_____State:_____Zipcode:_____ Phone:_____

Mother's Information	Father's Information
_____	Name_____
_____	Date of Birth_____
_____	Employer_____
_____	Home Phone_____
_____	Work Phone_____
_____	*Cell Phone*_____
_____	Social Security Number_____
_____	*EMAIL*_____

List names of brothers and sisters_____
Dental Insurance Company:_____ Policy #_____Group #_____Phone:_____
Name of Insured:_____ Name of Employer:_____
Whom may we thank for referring your child to us?_____
What is your child's favorite: school subject_____sport_____hobby_____person_____

Medical History

Does your child have any history of the following **medical conditions**? *(please check all that apply)*

- ☐ Abuse (physical/sexual)
- ☐ Anemia
- ☐ Asthma/Reactive airway disease
- ☐ ADD/ADHD
- ☐ Autism/Asperger's/PDD
- ☐ Bladder problems
- ☐ Bleeding disorders (prolonged)
- ☐ Blood transfusions
- ☐ Brain injury
- ☐ Cancer: Type_____
- ☐ Cerebral Palsy
- ☐ Cleft lip/palate
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Emotional/psychiatric disability
- ☐ Endocrine disturbance
- ☐ Eye problems
- ☐ Fainting/frequent headaches
- ☐ Gastrointestinal/reflux problems
- ☐ Hearing problems
- ☐ Heart problems/murmurs Type_____
- ☐ Hepatitis/liver disease
- ☐ HIV infection (AIDS)
- ☐ Kidney problems
- ☐ Learning disability
- ☐ Mental retardation
- ☐ Neurological disorders/shunts
- ☐ Orthopedic problems
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizure disorder Type_____
- ☐ Sickle Cell Disease/Trait
- ☐ Snoring
- ☐ Speech problems
- ☐ Spina Bifida
- ☐ Syndrome Type_____
- ☐ Tuberculosis
- ☐ Other comments_____

Is your child CURRENTLY taking any **medications**? ___No___Yes

Drug	Dosage and Frequency	Reason

Has your child ever taken or is currently taking bisphosphonates? ___No ___Yes_____
Has your child ever had an **allergic** reaction to: Antibiotics/medications ___ No ___Yes_____
Latex ___ No ___Yes_____
Dental anesthetics ___No ___Yes_____
Food ___No ___Yes_____
Other ___No ___Yes_____

Medical History

Child's Physician/Pediatrician:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Date of last physical exam:_____Are you child's immunizations current?___No___Yes

How is your child's general health?_____Height:_____Weight:_____

Were there any complications during pregnancy/delivery?___No___Yes_____

Has your child had any serious illness? ___No___Yes, explain_____

Has your child ever been hospitalized? ___No___Yes, where, when, why?_____

Has your child ever undergone surgery? ___No___Yes,where, when, why?_____

If yes, was general anesthesia used? ___No___Yes, were there any complications?__No___Yes_____

Has your child ever been told that they need antibiotics before dental treatment?___No___Yes

Are there any dental or medical health problems that you would like to talk about privately with the dentist? NO YES

Dental History

What brings you here today?_____

Date of last dental visit_____Reason for last visit_____

Name of previous dentist_____ Were x-rays taken?_____

How do you think your child will do today?_____

	Yes	No		Yes	No
Has your child complained about dental problems? _____			Does your child brush his/her teeth daily? AM PM both (circle)		
Are there any dental problems concerning you at this time?_____			Do you assist with the tooth brushing?		
Any injuries to mouth/teeth/head?_____ _____			Do you use dental floss?		
Any oral habits? thumbsucking, finger sucking, bottle, pacifier, tongue thrust, nail biting (circle)			Is fluoride used in any form? toothpaste, water, rinses, supplements (circle)		
Any unhappy dental experiences?_____ _____			Does your child snack between meals? What is the snack?_____		
Has your child ever worn any orthodontic appliances?_____			Does your child use a bottle/sippy cup? What is in the bottle?_____		

Are there any religious/moral beliefs that may limit our ability to fully treat your child? NO YES _____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medicines, I will inform the doctor at the next appointment without fail.

Signature:_____ Date:_____ Are you the child's legal guardian? YES NO (circle)