

MEDICAL HISTORY

Patient Name _____ Preferred Name _____

Birthdate _____ Age _____ (Circle) Male Female

SS# _____ Responsible Party Name _____

Child's Address _____

City, State, Zip _____ Phone _____

School _____ Referred By _____

Patient's Pediatrician _____ Phone _____

MEDICAL HISTORY

Previous hospitalizations/surgeries/serious illnesses? _____

Is Patient currently taking any medications? (If Yes, List) _____

Does Patient have a history of allergies to drugs or medications (Penicillin, Novocain, etc.)? (If Yes, List) _____

Does Patient have history of allergies to any other substances (latex, environmental, etc.)? (If Yes, List) _____

Does Patient have, or ever had, any of the following? (Circle)

Asthma?	Yes	No	Stomach, liver or kidney problems?	Yes	No
Cancer?	Yes	No	Handicaps/Disabilities?	Yes	No
Hepatitis?	Yes	No	Abnormal Bleeding?	Yes	No
HIV/AIDS?	Yes	No	Diabetes?	Yes	No
Hemophilia?	Yes	No	Rheumatic Fever?	Yes	No
Heart Murmur?	Yes	No	Congenital Heart Defect?	Yes	No
Tuberculosis?	Yes	No	Convulsions/Epilepsy?	Yes	No
Pregnancy?	Yes	No			

Please list any other medical problems the Patient has: _____

DENTAL HISTORY

Is this Patient's first visit to a dentist? (Circle) Yes No

If not, how long since last visit? _____

Previous Dentist: _____ Phone _____

Has Patient had difficulty with previous dental / medical visits? _____

How often does Patient brush? _____

How often does Patient floss? _____

What does Patient drink most often? _____

Does patient snore? (Circle) Yes No

Are tonsils and adenoids out? (Circle) Yes No

Breathe through mouth often? (Circle) Yes No

Does Patient... Suck thumb/finger/pacifier? Yes No

Suck/bite lip? Yes No

Bite/chew nails? Yes No

Chew hard objects (i.e. pencil)? Yes No

Grind teeth? Yes No

Clench jaws? Yes No

Have there been any injuries to teeth – falls, blows, chips, etc.? _____

Reason for today's visit: _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the Patient's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform necessary dental services my child may need. It is my responsibility to inform the dental office of any changes in medical status. 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.

Signature of Parent/Guardian _____

Date _____