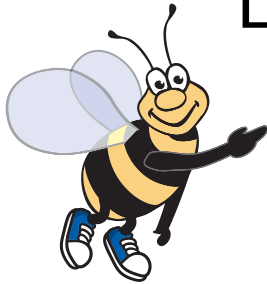
Thank you for completing our forms.



Look For Important

Check Boxes

Next To the Bee!

When complete, please print. If you can't print, please come early to complete in our office.

Scroll Down to Continue.

Medical History

Patient Information

First Name ______________________ Last Name ______________________ MI ______

Preferred Name ______________________ Date of Birth ______________ ❏ Male ❏ Female

Referred By ____

Are you the child's legal guardian? ❏ Yes ❏ No

Is your child currently established with a Pediatrician/Doctor? ❏ Yes ❏ No

Pediatrician/Doctor Name: ____

Is your child current with their routine medical exams and recommended immunizations? ❏ Yes ❏ No

Is your child under any specialty doctor's care for any physical for emotional concerns? ❏ Yes ❏ No

If yes, please list Doctor's name and reason.____

Does your child currently take any medications? ❏ Yes ❏ No

If yes, please list. ____

Has your child ever been hospitalized, had major operations or any serious head/neck injuries? ❏ Yes ❏ No

Is your child allergic to any of the following?

❏ Penicillin ❏ Sulfa Drugs ❏ Food allergies ❏ Latex ❏ Nuts ❏ None

Does your child have any other allergies that are of concern. (ex. Food, Dyes, etc) ❏ Yes ❏ No

Please list ALL allergies. ____

Does your child have any of the following?

❏ Asthma	❏ Lung Problems	❏ Blood Transfusion	❏ Kidney Disorder
❏ Autism	❏ Sickle Cell Anemia	❏ Vision Disorder	❏ Blood Disorder
❏ Heart Murmur	❏ Hepatitis	❏ Hearing Disorder	❏ Tuberculosis
❏ Down's Syndrome	❏ HIV/AIDS	❏ Speech Disorder	❏ Brain Injury
❏ Developmental Delay	❏ Rheumatic Fever	❏ Emotional Disorder	
❏ Diabetes	❏ Cerebral Palsy	❏ Thyroid Disorder	
❏ Epilepsy	❏ Heart Condition	❏ Liver Disorder	

Has your child ever had any serious illness not listed above? ❏ Yes ❏ No

Please comment on any condition noted above or any other medical concerns.

____

____

Dental History

Is this your child’s first visit to the dentist ❑ Yes ❑ No

Has your child had difficulty with previous dental/medical visits? ❑ Yes ❑ No

Does your child have any non-nutritive sucking habits? ❑ Yes ❑ No

❑ Thumb or Finger ❑ Pacifier ❑ Other: ____________________

Does your child: ❑ Snore ❑ Grind Teeth ❑ Breath Through Mouth Often ❑ None

Are your child’s tonsils and adenoids out? ❑ Yes ❑ No

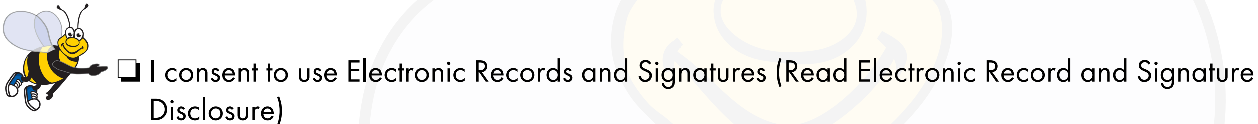
Has your child ever had any injuries to teeth (falls, blows, chips, etc) ❑ Yes ❑ No

Reason for Today’s Visit: ____________________

Comments/Chief Concerns: ____________________

Sign Form

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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.



❑ I consent to use Electronic Records and Signatures (Read Electronic Record and Signature Disclosure)

Typed Name as Signature ____________________ Date____________

Relationship to patient ____________________