

PERSONAL

PATIENT HISTORY

DATE _____

Child's Name _____ Nickname (if any) _____

Date of Birth _____ Sex: M F School _____ Grade _____

Home Address _____ City _____ State _____ Zip _____

Name and Age of Siblings _____

Interests or hobbies: _____

Parent's Marital Status: [] Single [] Married [] Separated [] Divorced [] Widowed

Parent Name _____ DOB: _____

Home Phone # _____ Cell # _____ email: _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Bus. Phone # _____

Business Address _____ City _____ State _____ Zip _____

Parent Name _____ DOB: _____

Home Phone # _____ Cell # _____ email: _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Bus. Phone # _____

Business Address _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You? _____

HEALTH INSURANCE INFORMATION

Dental Coverage

Medical Coverage

Subscriber (covered employee) _____

Subscriber (covered employee) _____

Date of Birth _____

Date of Birth _____

Employer providing insurance: _____

Employer providing insurance: _____

Name of insurance carrier (company): _____

Name of insurance carrier (company): _____

Group or Policy # _____

Group or Policy # _____

MEDICAL HISTORY

Child's Physician _____ Address _____ Phone # _____

Date of last physical examination? _____ Results _____

Is a physician treating your child now for a specific illness? Yes No
If so, for what reason? _____

Is your child taking any medication at this time? (including over-the-counter medications, vitamins, herbal supplements) Yes No
Drug Dose Frequency Reason

Has your child shown any allergies or unusual reactions?

- a) Medications or drugs _____
- b) Foods _____
- c) Other _____

Were there any problems with the birth or pregnancy? Yes No

Was your child hospitalized for a period longer than normal after birth? Yes No
Why? _____

Has your child ever been hospitalized? If so, Yes No
When? _____

For what reason? _____

Has your child had any operations? If so, Yes No
When? _____

For what reason? _____

Are there any psychological or emotional problems you would like to bring to our attention? Yes No

Does your child have any history of the following diseases or conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney/Bladder Problems |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Liver Problems, Jaundice or Hepatitis |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Asthma or Lung Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychological/Mood Disorders |
| <input type="checkbox"/> Blood/Clotting Disorders | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Seizures, Epilepsy |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Severe Infections |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Heart Murmurs/Congenital Heart Disease | <input type="checkbox"/> Speech/Hearing Disorder |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other, if so explain _____ | | |

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION THE DENTIST SHOULD BE AWARE OF, OR THAT HAS NOT BEEN COVERED ABOVE.

DENTAL HISTORY

Why did you make this appointment? _____

Does your child have any of the following habits? (indicate ages when occurred)

Is this your child's first visit to a dentist? Yes No

Bottle to bed at night or nap _____

If not, how long since the last dental visit? _____

What was in bottle? _____

Child's previous dentist:

Use a pacifier? _____

Name _____

Thumb or finger sucking _____

Address _____

Tongue thrusting _____

Approximate date of last dental "x-rays" _____

Lip sucking or biting _____

Has your child ever had any unpleasant dental experience? Yes No

Mouth breathing _____

If so, please explain: _____

Grinds Teeth _____

Does your child brush his/her own teeth? Yes No

How frequently and when? _____

Do you brush your child's teeth? Yes No

How frequently and when? _____

Do you or your child use dental floss in cleaning your child's teeth? Yes No

How frequently and when? _____

Fluoride: (please circle)

What type of water do you have at your home? Well Public

Do you have fluoride in your water? Yes No Don't Know

If no, does your child take a fluoride supplement - drops or tablets? Yes No Don't Know

Toothpaste Type and Brand _____

Have your child's teeth ever been injured? Yes No

When? _____

Which Teeth? _____

Cause? _____

Were the teeth treated? Yes No

If so describe treatment _____

Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. If there are any changes, or omissions to the patient's medical history, it is my responsibility to inform the dental office before treatment begins.

Signature _____ Relationship _____ Date _____

SUMMARY: (FOR DOCTOR'S USE) REVIEWER: _____ DATE: _____

MEDICAL
DENTAL