PERSONAL **PATIENT HISTORY** DATE________________

Child's Name ______________________________ Nickname (if any) ______________
First Middle Last

Date of Birth ______________ Age ____ 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 ______________________ Social Security # ______________

Home Phone # ______________ Cell # ______________ email: ______________

Home Address ______________________ City __________ State ______ Zip________

Employer ______________________ Occupation __________ Bus. Phone #____________

Business Address ______________________ City __________ State ______ Zip________

Parent Name ______________________ Social Security # ______________

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 ☐

Subscriber (covered employee) ______________

Date of Birth ______________

Employer providing insurance: ______________

Name of insurance carrier (company): ______________

Group or Policy # ______________

Medical Coverage

Subscriber (covered employee) ______________

Date of Birth ______________

Employer providing insurance: ______________

Name of insurance carrier (company):______________

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?

- ☐ Autism
- ☐ ADD/ADHD
- ☐ AIDS/HIV+
- ☐ Asthma or Lung Problems
- ☐ Blood/Clotting Disorders
- ☐ Blood Transfusions
- ☐ Cancer/Tumors
- ☐ Celiac Disease
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Headaches
- ☐ Heart Murmurs/Congenital Heart Disease
- ☐ Intellectual Disability
- ☐ Kidney/Bladder Problems
- ☐ Liver Problems, Jaundice or Hepatitis
- ☐ Lyme Disease
- ☐ Psychological/Mood Disorders
- ☐ Seizures, Epilepsy
- ☐ Severe Infections
- ☐ Speech/Hearing Disorder
- ☐ Thyroid Disease
- ☐ 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? ____________________

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

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

Child's previous dentist:

Name ____________________

Address ____________________

Approximate date of last dental "x-rays" __________

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

If so, please explain: ____________________

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

Bottle to bed at night or nap __________

What was in bottle? __________

Use a pacifier? __________

Thumb or finger sucking __________

Tongue thrusting __________

Lip sucking or biting __________

Mouth breathing __________

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