PEDIATRIC DENTISTRY
JOSEPH A YALE, DDS
KATIE McCLENDON, DDS
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245 VETERANS BLVD. • DENHAM SPRINGS, LA 70726

Child's Name _____ Birthday _____ / _____ / _____

Medical History

Child's Physician _____ Address _____ Phone # (____)_____

Date of Last Visit _____ Reason_____

Is your child in good physical health?	❑ Yes	❑ No	
Is your child up to date with immunizations?	❑ Yes	❑ No	
Has your child been hospitalized since birth?	❑ Yes	❑ No	
Was child born premature?	❑ Yes	❑ No	How many weeks early? _____

Please check any of the following that may pertain to your child

___ADD/ADHD	___Brain Injury	___Eczema	___Kidney Problem	___Sickle Cell Anemia
___Aids'/HIV+	___Cancer	___Epilepsy	___Latex Allergy	___Sight Problems
___Allergies	___Cerebral Palsy	___Handicaps	___Learning Disability	___Snoring/Sleep Apnea
___Anxiety	___Chemo/Radiation	___Hearing Problems	___Liver Problem	___Syndrome:_____
___Asthma	___Congenital Birth Defect	___Heart Condition	___Lung Problem	___Other
___Autism	___Cystic Fibrosis	___Heart Murmur	___Psychiatric Disorder	
___Bleeding Problem	___Diabetes	___Hepatitis	___Seizures	

Please describe any medical condition that was checked above **or any condition that was not listed:**

_____

Please list all medications your child is taking _____

Is your child allergic to any medications, food, etc.? ❑ Yes ❑ No If yes, list_____

Dental History

Reason Your Child Is Here Today _____

Is this your child's first dental visit? _____ Date of Last Visit _____ Were X-Rays taken? _____

Has your child had an unfavorable experience in a dental office? _____

If yes, please explain _____

Child's Previous Dentist _____ Address _____ Phone # (____)_____

What is your water source?	❑ Private Well	❑ Public System	
Does your child suck their thumb or finger?	❑ Yes	❑ No	
Does your child use a pacifier?	❑ Yes	❑ No	
Was your child bottle fed?	❑ Yes	❑ No	Age it was discontinued _____
Has your child ever had trauma to their teeth?	❑ Yes	❑ No	
Do you assist your child with tooth brushing?	❑ Yes	❑ No	❑ Sometimes

Permission

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsiblitity to inform this office of any changes in my child's medical status.

Parent/Guardian's Signature _____

Date _____