PEDIATRIC DENTISTRY
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Child's Name _____ Birthday ____/____/____

Medical History

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

Date of last visit _____ Reason _____

Has your child been hospitalized since birth? ❑ Yes ❑ No Explain _____

Please list all medications your child is taking _____

Does your child see a specialist? ❑ Yes ❑ No Name & Phone # _____

Is your child in any type of therapy? ❑ Yes ❑ No Explain _____

Was your child born premature? ❑ Yes ❑ No How many weeks? _____

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

_____

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

AIDS/HIV+ ❑ Yes ❑ No	Chemo/Radiation ❑ Yes ❑ No	Heart Condition ❑ Yes ❑ No	Lung Disorder ❑ Yes ❑ No
ADD/ADHD ❑ Yes ❑ No	Congenital Birth Defect ❑ Yes ❑ No	Heart Murmur ❑ Yes ❑ No	Mitral Valve Prolapse ❑ Yes ❑ No
Allergies ❑ Yes ❑ No	Cystic Fibrosis ❑ Yes ❑ No	Hemophilia ❑ Yes ❑ No	Pregnant ❑ Yes ❑ No
Anxiety/Depression ❑ Yes ❑ No	Developmental Delay ❑ Yes ❑ No	Hepatitis A B C ❑ Yes ❑ No	Psychiatric Disorder ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Diabetes ❑ Yes ❑ No	Hypoglycemia ❑ Yes ❑ No	Seizures ❑ Yes ❑ No
Autism ❑ Yes ❑ No	Eczema ❑ Yes ❑ No	Intestinal Disease ❑ Yes ❑ No	Sickle Cell Anemia ❑ Yes ❑ No
Brain Injury ❑ Yes ❑ No	Epilepsy ❑ Yes ❑ No	Kidney Disorder ❑ Yes ❑ No	Snoring/Sleep Apnea ❑ Yes ❑ No
Cancer ❑ Yes ❑ No	Handicaps ❑ Yes ❑ No	Learning Disability ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No
Cerebral Palsy ❑ Yes ❑ No	Hearing Problems ❑ Yes ❑ No	Liver Disorder ❑ Yes ❑ No	Vision Problems ❑ Yes ❑ No

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

_____

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? ❑ Yes ❑ No

If yes, please explain _____

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

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 Explain _____

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 responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian's Signature _____

Date _____