



(225) 664-2646 • (225) 664-2640 (fax)
245 VETERANS BLVD. • DENHAM SPRINGS, LA 70726

PEDIATRIC DENTISTRY

JOSEPH A YALE, DDS
KATIE McGLENDON, DDS
KATHLEEN CORBIN, DDS

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

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Aids'/HIV+ | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Sight Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Handicaps | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Snoring/Sleep Apnea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chemo/Radiation | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Syndrome: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital Birth Defect | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Disorder | |
| <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> 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 responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian's Signature _____

Date _____