ACCT# _____

Medical History

Child's Name _____ DOB ___/___/___ ☐ Female ☐ Male

Has your child ever had the following medical conditions?

☐ Y ☐ N Anemia	☐ Y ☐ N Developmental Delays	☐ Y ☐ N Kidney Disease
☐ Y ☐ N Asthma	☐ Y ☐ N Diabetes	☐ Y ☐ N Learning Disability
☐ Y ☐ N ADD/ADHD	☐ Y ☐ N Dizziness	☐ Y ☐ N Liver Disease
☐ Y ☐ N Any Hospital Stays	☐ Y ☐ N Fainting	☐ Y ☐ N Nervous Disorder
☐ Y ☐ N Autism	☐ Y ☐ N Hepatitis	☐ Y ☐ N Respiratory Disease
☐ Y ☐ N Behavioral Issues	☐ Y ☐ N Hearing Impairments	☐ Y ☐ N Sickle Cell Anemia
☐ Y ☐ N Bleeding Disorder	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Speech Delays
☐ Y ☐ N Cancer/Tumor	☐ Y ☐ N Heart Problems	☐ Y ☐ N Tobacco Use
☐ Y ☐ N Cerebral Palsy	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Vision Problems
☐ Y ☐ N Epilepsy	☐ Y ☐ N HIV/AIDS	☐ Y ☐ N Other

Please discuss any above medical conditions that you marked ☑ Y :

_____

_____

_____

Please list any medication(s) your child is currently taking: _____

Is your child allergic to: ☐ Penicillin ☐ Latex ☐ Codeine ☐ Metals ☐ Other _____ ☐ None Known

Are your child's immunizations up to date? ☐ Yes ☐ No **Is this patient pregnant?** ☐ Yes ☐ No

Child's Physician _____ **Phone** _____

CHILD'S DENTAL HISTORY

What is your chief concern regarding your child's dental health? _____

Is your water source: ☐ City ☐ Well **Do you have a reverse osmosis system?** ☐ Yes ☐ No

Is your child taking fluoride supplements? ☐ Yes ☐ No **Does your child use a fluoride rinse?** ☐ Yes ☐ No

Does your child do/use any of the following?

☐ Thumb/Finger Sucking	☐ Nursing	☐ Bottle/Sippy Cup	☐ Mouth Breathing
☐ Pacifier	☐ Teeth Grinding/Clenching	☐ Tongue Thrusting	☐ Pain in Jaw (TMD)

Parent's Dentist _____ **Phone** _____

AUTHORIZATION

The health history information provided above is true and complete to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's dental health or other information.

_____ _____ _____

Signature of Parent or Guardian | Date | Staff Initials

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PEDIATRIC DENTISTRY