Child Medical History

Date_____

Patient Information

First Name:_____ Middle Initial:_____ Last Name:_____

Mother's Name:_____ Father's Name:_____ Guardian's Name:_____

Primary Phone #:_____ (M/F/G) Secondary Phone #:_____ (M/F/G)

Address:_____

Date of Birth:_____ Social Security #:_____ Sex:_____

Address of Parent if different from the child:_____ (M/F)

Hobbies and Interests:_____

Sibling's Name(s):_____ Pet's Name(s):_____

Primary Insurance Information

Policy Holder's Name:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

Date of Birth:_____ Social Security Number/ID Number:_____

Employer:_____ Dental Insurance Company:_____

Mailing Address:_____ Group #:_____

Secondary Insurance Information

Policy Holder's Name:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

Date of Birth:_____ Social Security Number/ID Number:_____

Employer:_____ Dental Insurance Company:_____

Mailing Address:_____ Group #:_____

Medical Information

Physician's Name:_____ Hospital:_____

City:_____ State:_____ Phone:_____ Date of Last Visit:_____

Is your child currently undergoing any medical treatment with a physician? If so, what for?_____

_____

Have they had any surgeries? If so, please list._____

Yes	No	**Please mark an X for the following questions accordingly. Please explain any YES answers in the designated area below.**
		Do they have any Eye, Ear, Nose or Throat problems? (Ex. Glasses, Hearing Impairment, etc.)
		Do they have any Heart problems? (Ex. Heart Murmur, Congenital Heart Disease, etc.)
		Do they have any Breathing or Lung problems? (Ex. Asthma, Cystic Fibrosis, Pneumonia, etc.)
		Do they have any Stomach, Intestine, or Liver disorders? (Ex. Crohn's, Acid Reflux, Celiac's, IBS, etc.)
		Do they have an Eating disorder? (ex. Bulimia, Anorexia, Purging, etc.)
		Do they have any Kidney or Urinary disorders? (Ex. Urinary Tract Infection, etc.)
		Do they have any Muscle or Bone disorders? (ex. Muscular Dystophy, Joint Problems, etc.)
		Do they have any skin problems? (Ex. Eczema, Psoriasis, etc.)
		Do they have any Neurologic or Nerve problems? (Ex. Seizures, Head Injury, etc.)
		Do they have any Mental Health disorders? (Ex. Depression, Anxiety, etc.)
		Do they have any Diabetes or Endocrine disorders? (Ex. Type 1, Type 2, Thyroid Problems, etc.)
		Do they have any Blood or Hematologic disorders? (Ex. Anemia, Leukemia, Sickle Cell, etc.)
		Do they have any Immune System disorders? (Ex. Lupus, etc.)
		Do they have any Infectious diseases? (Ex. Hepatitis A, B/D, or C, STD, HIV/AIDS, cold sores, etc.)
		Do they have any joint replacements? (Ex. Hip, Knee, Shoulder, Elbow, Ankle, etc.)
		Do they use any tobacco products, illicit drugs, or alcohol? If yes, what and how often?
		Do they pre-medicate prior to Dental Treatment for any of the following reasons? Artificial Heart Valve, Previous Infective Endocarditis, Heart Transplant, Congenital Heart Disease

Please explain any YES answers from the previous list of questions:

_____
_____
_____
_____
_____

Yes	No	FEMALES ONLY
		Are they or could they be pregnant? If yes, how many weeks?
		Are they currently nursing?
		Are they taking any birth control, Fertility Drugs or Hormone replacements?

Does your child currently take any medications? Prescription, over the counter, dietary supplements, herbal medicine or vitamins? (If they have more than five medications, we would be happy to make a copy of their list for you)

Medications or Supplements	Dose	Frequency	Date Started	Reason for Use

Under no circumstance will we ever advice you to stop taking any of your medications.

Please list any allergies to any medications, metals, latex, or food?_____

Dental Information

Previous Dentist:_____Date of Last Dental Exam:_____

Address_____Office Phone:_____

Do you have current x-rays that you would like transferred to our office? Yes/No_____

Do you have any concerns with your child's smile?_____

Yes	No	**Please mark an X for the following questions accordingly.**
		Is this your child's first visit?
		Does your child brush their teeth twice daily? If no, how often?
		Does your child floss or Waterpik daily? If no, how often?
		Do you or someone assist your child with Brushing and Flossing?
		Does your child's gums bleed when they brush and floss?
		Does your child have any teeth that are sensitive to hot, cold, sweets, or pressure?
		Is your child's mouth dry?
		Does your child suck on their thumb, fingers, or pacifier?
		Has your child gone through orthodontic (braces) treatment? If yes, When?
		Is their home water supply fluoridated?
		Does your child brux, clench, or grind their teeth?
		Does your child have any sores or ulcers in your mouth?

Note: Both Patient and Doctor are encouraged to discuss any and all relevant health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian:_____