PEDIATRIC MEDICAL/DENTAL HISTORY

Date _____

Preferred Language _____

Child's Full Name _____Nickname_____Sex [ ] F [ ] M

Date of Birth_____/_____/_____(mm/dd/yyyy) Height_____ Weight_____

Street Address _____ Home phone _____-_____-_____

City _____ State _____ Zip Code _____

Parent 1 _____ Cell phone _____-_____-_____

Email address _____ Work phone _____-_____-_____

Parent 2 _____ Cell phone _____-_____-_____

Email address _____ Work phone _____-_____-_____

How did you hear about our office: [ ] Referred [ ] Insurance Company [ ] Website [ ] Other _____

MEDICAL HISTORY:

Physician's Name _____ Phone _____-_____-_____

Date of last physical _____ Results: [ ] Excellent [ ] Fair [ ] Poor

Is child being treated for any medical condition? YES NO

If yes, please provide medical specialists name, phone number and brief explanation:

_____

_____

_____

Does child bleed excessively for a cut or extraction? YES NO

Has child ever had a reaction to or problem with an anesthetic? YES Describe:_____ NO

Is child required to take antibiotic premedication before dental treatment? YES NO Has child ever been hospitalized? YES NO

If yes, please provide a brief explanation:

_____

_____

List all medications (**prescription or over the counter**) child is currently taking:

_____

_____

_____

_____

_____

ALLERGIES:

[ ] Aspirin [ ] Nuts _____

[ ] Codeine [ ] Metals

[ ] Latex [ ] Local Anesthetic

[ ] Food Dyes [ ] Antibiotics _____

[ ] Sulfa [ ] Other_____

Is child up to date on immunizations against childhood diseases? YES NO

Circle Y for **YES** or **N** for **NO** if your child has ever had / has any of the following:

Y N ADD / ADHD **Y N** Seizures/ Epilepsy **Y N** Heart Murmur **Y N** Psychiatric Disorder

Y N AIDS / HIV Positive **Y N** Cancer **Y N** Hemophilia/ Bruising Easily **Y N** Rheumatic Fever

Y N Eczema/ Skin Issues **Y N** Cerebral Palsy **Y N** Hepatitis / Liver Problems **Y N** Sickle Cell Disease / Trait

Y N Artificial Bones / Joints **Y N** Congenital Heart Defect **Y N** Kidney Disease **Y N** Behavioral/ Emotional Issues

Y N Acid Reflux Disease	**Y N** Cystic Fibrosis	**Y N** Thyroid Problems	**Y N** Arthritis
Y N Tonsil Infections	**Y N** Diabetes	**Y N** Learning Problems	**Y N** Transfusions
Y N Asthma (RAD)	**Y N** Eye Problems	**Y N** High Blood Pressure	**Y N** Tuberculosis (TB)
Y N Autism/ ASD	**Y N** Fainting	**Y N** Mononucleosis	**Y N** Yellow Jaundice
Y N Bleeding Problems	**Y N** Febrile Seizures	**Y N** Physical Disability	**Y N** Sleep Apnea/ Mouth Breathing
Y N Brain Injury	**Y N** Hearing Loss	**Y N** Pregnancy	**Y N** Exposure to Tobacco Smoke

Has your child ever had any illness or medical condition not listed…….. YES NO

If yes, explain _____

DENTAL HISTORY

Reason for visit: [ ] Consult / Examination [ ] Pain [ ] New Patient [ ] First Visit

If your child has been treated by a previous dentist, please provide the practice name, phone number, last visit date and if X-Rays were taken at the visit:

_____

_____

_____

Is there a family history of cavities? **Y N**

Are there any oral health concerns you would like our staff to address with you or the patient today? **Y N -**

_____

_____

_____

How would you describe:

Your child's oral health?	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor	
Your oral health?	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor	
The oral health of your other children?	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor	[ ] N/A

How frequently does your child have the following:

Candy or other sweets	[ ] Rarely	[ ] 1-2 times/day	[ ] 3 or more times/day
Chewing gum	[ ] Rarely	[ ] 1-2 times/day	[ ] 3 or more times/day
Snacks between meals	[ ] Rarely	[ ] 1-2 times/day	[ ] 3 or more times/day
Soft drinks	[ ] Rarely	[ ] 1-2 times/day	[ ] 3 or more times/day

Does someone help your child brush/floss? **Y N**

When does your child brush their teeth? [ ] Morning [ ] Night [ ] Both

Was the child breast or bottle fed? _____ until age ____

Did the patient sleep with a bottle? **Y N**

What month did the patient's first tooth erupt? _____ At what age did you begin brushing the patient's teeth? _____

Has the child ever had a serious / difficult problem associated with previous dental treatment? **YES NO**

If yes, explain _____

Circle Y for **YES** or **N** for **NO** for all that applies to your child:

Y N Finger / Thumb Sucking	**Y N** Nail biting	**Y N** Pacifier
Y N Well water	**Y N** Fluoride Supplements	**Y N** Injuries to mouth / teeth / head
Y N Unhappy dental experience	**Y N** Current dental issues	**Y N** Clenching/grinding teeth
Y N Excessive gagging	**Y N** Bad Breath	**Y N** Mouth sores/ fever blisters

Does our office see any siblings or relatives of the patient? Y N
If yes, please provide a list of the patients we see: _____ _____

_____ _____

_____ _____

INSURANCE INFORMATION:

Insurance Co. Name _____ Phone _____-_____-_____ Group#(Plan, Local or Policy#) _____

Insurance Co. Address _____

Subscriber's Name _____ Relationship to patient _____

Subscriber's Birthdate _____/_____/_____ (mm/dd/yyyy) SSN/ID# _____

Subscriber's Employer _____ Work phone _____-_____-_____

I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for balance not covered by my insurance. I authorize the use of my signature on all of my insurance submissions, whether manual or electronic.

_____

Parent / Guardian signature

_____

Signature of staff member reviewing history

INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT

Delaying treatment may allow dental disease to progress to an emergency situation, including, but not limited to: abscess formation, infection, pain, fever and risk to the developing permanent teeth, or contribute to a long-term dental problem.

The most common complications associated with pediatric dental treatment include nausea, trauma to soft tissue, prolonged numbness and bruising following the administration of local anesthesia. Less common complications include, but are not limited to: infection, swelling, prolonged bleeding, vomiting, allergic reaction, nerve injuries, further degeneration of restored teeth, fracture or teeth during extractions (requiring surgical treatment), brain damage and even loss of bodily function or life.

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or staff responsible for any errors due to omissions that I may have made in the completion of this form. It is ultimately my responsibility to inform the office of any changes in my medical history, personal information and insurance information The parent or Guardian who accompanies the child is responsible for payment at time of service. We reserve the right to charge for any appointments that are cancelled or broken without 24 hours advanced notice.

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Parent / Guardian Signature Date

DO NOT WRITE BELOW THIS LINE **FOR OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian and the patient named herein.

MEDICAL HISTORY UPDATE

Intials: _____ **Date:** _____ **1. Date:** _____ **Signature:** _____

Comments: _____

Doctor's Comments: _____ _____

_____ **1. Date:** _____ **Signature:** _____

_____ **Comments:** _____

_____ _____