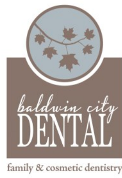

PEDIATRIC MEDICAL & DENTAL HISTORY FORM

Today's date ________________

First Name ___________________________ **MI**______ **Last Name**______________________________ **DOB**__________

What is the reason for today's visit? ____

MEDICAL HISTORY

Is your child taking any medications (prescription and/or over the counter)? Y N **Please list**______________________________________

Is your child allergic to any medications (antibiotics, anesthetics etc.)? Y N **Please list**______________________________________

Is your child allergic to any foods or materials (latex, metals, etc.)? Y N **Please list**______________________________________

Has your child ever been hospitalized or had surgery? Y N **When**________________ **Reason** ___________________________

Does your child have any health problems? Y N **Please Explain** ____

Is your child subject to any nervous system disorders? Y N
_____ **Fainting** _____ **Seizures** _____ **Anxiety** _____ **Other**_______________________

Has your child had any history or ever been diagnosed with any of the following (mark all that apply:

_____Anemia	_____Brain Injury	_____Hearing Loss	_____Mumps
_____Allergy/Hay Fever	_____Brain Surgery	_____Heart Murmur	_____Pneumonia
_____Arthritis/Rheumatism	_____Cancer	_____Heart Problems/Surgery	_____Polio
_____Artificial Heart Valve	_____Cerebral Palsy	_____Hemophilia	_____Pregnancy
_____Artificial Joint/Limb	_____Chemotherapy	_____Hepatitis	_____Rheumatic Fever
_____Asthma	_____Chicken Pox	_____High/Low Blood Pressure	_____Scarlet Fever
_____ADD or ADHD	_____Chronic Sinusitis	_____HIV/AIDS	_____Scoliosis
_____Autism	_____Cleft Lip/Palate	_____Hormonal Disturbances	_____Shunt
_____Behavior/Learning Disability	_____Diabetes	_____Kidney Problems	_____STD
_____Epilepsy/Seizures	_____Digestive Problems	_____Liver Problems	_____Tetanus
_____Birth Defects	_____Eye Problems	_____Malignant Hyperthermia	_____Tuberculosis
_____Bleeding Disorder	_____Fainting	_____Measles	_____Whooping Cough
_____Bone/Joint Problem	_____Growth Problems	_____Mental Deficiency/Disorder	_____Other

DENTAL HISTORY

Name of previous dentist: ____________________________ **Approximate date of child's last dental visit :** ________________

What was done at this visit? (Cleaning & Exam, Fillings, etc.): ____

How often does your child brush?: ___________________ **How often does your child floss?**___________________

Has your child...

Had cavities in the past? Y N
Had any teeth extracted? Y N
Had orthodontic treatment? Y N
Had any injury to teeth/gums? Y N

Does /Did your child…

Suck their thumb/pacifier excessively? Y N
Have anxiety about dental treatment? Y N
Consume lots of sugary snacks/drinks? Y N

Is there anything you would like us to emphasize to your child?: ____

Is there anything else you would like us to know about your child?: ____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

Signature of Legal Guardian: [ ] **Date**______________