Patient Medical History

GENERAL

Patient's Name: ______________________________ **Preferred Name:** ______________________

Preferred Pronouns: ____________________

☐ **If there have been NO CHANGES to your child's medical history, please check this box and sign below.**

DENTAL

Does/Is/Has your child:

o Yes o No Up to date on all immunizations?

o Yes o No Exhibit any oral habits? If so, please explain/list: ____

o Yes o No Experiencing any jaw symptoms (i.e. clenching, grinding teeth, TMJ pain, etc.)?

o Yes o No Snore at night?

o Yes o No Gag easily?

o Yes o No Brush daily? If so, how often? __________Floss daily? If so, how often?__________/day

o Yes o No Require antibiotics for dental work?

o Yes o No Presently in dental pain?

o Yes o No Experienced trauma to the head, face, or teeth (either presently or in the past)? If so, please circle the one that applies.

o Yes o No (Only for infants/toddlers) Breast or bottle fed (circle appropriate option)? When discontinued?: ________

o Yes o No (Only for infants/toddlers) Use a pacifier? If not, when discontinued?: _________

Describe the **primary** concern with your child's teeth:________________________

MEDICAL

Does your child have a history of any of the following? If so, please circle whichever apply and explain below:

O Asthma/Respiratory problems
O Autism/ADD/ADHD
O Brain Injury
O Bleeding disorder/Delay/Anemia
O Cancer
O Tuberculosis
O Herpes/Fever Blisters
O Congenital Heart Defect/Problem
O Other:____________

O Epilepsy/Seizures
O Endocrine
O Gastrointestinal/Kidney
O Heart Murmur
O Surgery
O Cerebral Palsy/CNS problem
O Vision Disorder

O Mental Disorder
O Rheumatic Fever
O Speech/Developmental Delay
O Transfusion
O Lung Problems
O Diabetes
O Hepatitis/Liver/Infectious Disease

Please explain: ____

Current medications (name and dosage)?: ____

Allergies or adverse reactions to any medications or substances (e.g. penicillin/sulfas, latex, food, etc.)?:

____

Authorization and Release: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary. I may be requested to release my child's medical and dental records and I agree to release my child's records to another doctor at their/your request.

Signature of Parent/Guardian: ____________________________________ Date: ___________

FOR NEW PATIENTS ONLY

Previous Dentist/Dental Office: _______________________ Date of last dental visit: ___________

Child's Pediatrician:____________________ Phone Number: ______________________