Patient Medical History (<8 years)

Grins
PEDIATRIC DENTISTRY

Child's Name: _____
Describe the primary concern with your child's teeth_____
Has your child had any unfavorable reactions to past dental treatment? If so, please explain: _____
What things does your child enjoy?_____

DENTAL

Does/Is your Child:

o Yes o No	Take Fluoride Supplements
o Yes o No	Use a pacifier, suck thumb/finger/lip, bite lip If so, please circle answer
o Yes o No	Bite or chew nails
o Yes o No	Grind teeth/clench Jaws/have TMJ pain? If so, please circle answer
o Yes o No	Gag easily
o Yes o No	Brush daily If so, how often?___ Floss daily? o Yes o No If so, how often?____
o Yes o No	Breastfed Age discontinued_____
o Yes o No	Bottlefed Age discontinued_____
o Yes o No	Require Antibiotics for dental work?
o Yes o No	Need dental work completed (referred from another dentist or you feel they do)
o Yes o No	Presently in dental pain?
o Yes o No	Have any extra, missing, or extracted teeth? If so, please circle answer
o Yes o No	Have a history/present today with trauma to the head, face, or teeth? which one?
o Yes o No	Have any other habits not listed above? If yes please specify_____

MEDICAL

Please check any that may apply to your child & circle exact answer

O Immunizations up to date
O Asthma/Respiratory problems O Epilepsy/Seizures O Mental Disorder
O Autism/ADD/ADHD O Endocrine O Rheumatic Fever
O Brain Injury O Gastrointestinal/Kidney O Speech Delay
O Bleeding disorder/Delay/Anemia O Heart Murmur O Transfusion
O Cancer O Hepatitis/Liver/Infectious Dis O Tuberculosis
O Cerebral Palsy/CNS problem O Herpes/Fever Blisters O Vision Disorder
O Congenital Heart Defect/Problem O Diabetes O Lung Problems O Developmental Delay
O Drug/Alcohol Abuse
O Other:_____

If you said yes to any of the above, please explain:_____
Current medications & dosages taken:_____
Allergies or adverse reactions to any medications (e.g. penicillin/sulfas): _____
Allergies to any substances (e.g. latex): _____
Previous hospitalizations, surgeries, or serious illnesses, and date: _____
Has your child had any abnormal bleeding associated with previous extractions, surgery, or trauma? (If yes, please explain): _____
Date of last dental visit (if new patient): _____ Previous Dentist: _____
Child's Pediatrician:_____ Phone Number: _____
Is there anything else you would like us to be aware of regarding your child?: _____

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: _____