Patient Medical History (8+ years)

GENERAL

Your/Child's Name: ____

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

DENTAL

Does you/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: _________