

Patient Demographics, Medical and Dental History

Patient Name: _____ DOB: _____ SSN: _____

Parents Names: _____ Primary Insurance Carrier: Mother Father

Primary Contact Tel: _____ Work Tel: _____ Mobile: _____

Email Address: _____ School/Preschool: _____

Address: _____

Referral Source: _____

Primary Insurance Carrier: DOB: _____ SSN: _____ Employer: _____

Insurance Company: _____ Group No: _____ Insurance Phone: _____

Claims Address: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dental care that he/she receives. Thank you for answering the following questions.

Primary Physician Name: _____ Telephone: _____

Is your child under the care of a specialist for any medical condition? Yes No

If, yes: Specialist Physician Name: _____ Telephone: _____

Does your child have or has had any of the following medical conditions?

| | | | |
|---------------------|--|-----------------------|--|
| AIDS/HIV | Yes <input type="radio"/> No <input type="radio"/> | Anemia | Yes <input type="radio"/> No <input type="radio"/> |
| Artificial Joint | Yes <input type="radio"/> No <input type="radio"/> | Asthma | Yes <input type="radio"/> No <input type="radio"/> |
| Blood Disease | Yes <input type="radio"/> No <input type="radio"/> | Breathing Problem | Yes <input type="radio"/> No <input type="radio"/> |
| Cancer | Yes <input type="radio"/> No <input type="radio"/> | Chemotherapy | Yes <input type="radio"/> No <input type="radio"/> |
| Cold Sores | Yes <input type="radio"/> No <input type="radio"/> | Diabetes | Yes <input type="radio"/> No <input type="radio"/> |
| Emphysema | Yes <input type="radio"/> No <input type="radio"/> | Epilepsy/Seizures | Yes <input type="radio"/> No <input type="radio"/> |
| Excessive Bleeding | Yes <input type="radio"/> No <input type="radio"/> | Fainting/Dizziness | Yes <input type="radio"/> No <input type="radio"/> |
| Frequent Headaches | Yes <input type="radio"/> No <input type="radio"/> | Heart Murmur | Yes <input type="radio"/> No <input type="radio"/> |
| Hemophilia | Yes <input type="radio"/> No <input type="radio"/> | Hepatitis | Yes <input type="radio"/> No <input type="radio"/> |
| Kidney Problems | Yes <input type="radio"/> No <input type="radio"/> | Liver Disease | Yes <input type="radio"/> No <input type="radio"/> |
| Lung Disease | Yes <input type="radio"/> No <input type="radio"/> | Mitral Valve Prolapse | Yes <input type="radio"/> No <input type="radio"/> |
| Psychiatric Care | Yes <input type="radio"/> No <input type="radio"/> | Renal Dialysis | Yes <input type="radio"/> No <input type="radio"/> |
| Rheumatic Fever | Yes <input type="radio"/> No <input type="radio"/> | Rickets | Yes <input type="radio"/> No <input type="radio"/> |
| Scarlet Fever | Yes <input type="radio"/> No <input type="radio"/> | Seasonal Allergies | Yes <input type="radio"/> No <input type="radio"/> |
| Sickle Cell Disease | Yes <input type="radio"/> No <input type="radio"/> | Spina Bifida | Yes <input type="radio"/> No <input type="radio"/> |
| Stomach Disease | Yes <input type="radio"/> No <input type="radio"/> | Thyroid Disease | Yes <input type="radio"/> No <input type="radio"/> |
| Tonsillitis | Yes <input type="radio"/> No <input type="radio"/> | Tumors or Growths | Yes <input type="radio"/> No <input type="radio"/> |
| Ulcers | Yes <input type="radio"/> No <input type="radio"/> | Jaundice | Yes <input type="radio"/> No <input type="radio"/> |

Has your child ever had any serious illness not listed above? Yes No

If yes, explain _____

Does your child take an medications either orally or inhaled? Yes No
 If yes, please list names and doses. _____

Has your child ever had a surgery or been in the hospital? Yes No
 If yes, when and what for? _____

Allergies to medications, latex, metals, and/or foods? Yes No
 If yes, please list. _____

Reason for your child's last dental visit. _____

Who was your child's previous dentist? _____

Date of your child's last dental x-rays. _____

Has your child had any complications following dental treatment? Yes No
 If yes, explain. _____

Has your child had any injury to the teeth, jaws, or face? Yes No
 If yes, explain. _____

Are you unhappy with the appearance of your child's teeth? Yes No
 If yes, explain. _____

Do your child's gums bleed with brushing? Yes No
 If yes, where? _____

Are any of your child's teeth sensitive to hot, cold or eating? Yes No
 If yes, where? _____

Does your child complain of a toothache? Yes No
 If yes, explain. _____

Does your child experience pain or clicking in the jaw joints? Yes No
 If yes, explain. _____

Are there any growths in your child's mouth? Yes No
 If yes, where? _____

Does your child suck fingers, thumb or pacifier? Yes No

Do you use toothpaste that contains fluoride? Yes No

Do you use any form of supplemental fluoride rinse or tablets? Yes No

Do you think your child will cooperate for dental treatment? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information or omitting information can be dangerous to my child's health. It is my responsibility to inform the dental staff of any changes in medical status.

Parent/Guardian Signature: _____ Date: _____

Summary of Findings: _____

Dentist's Signature: _____ Date: _____