

PATIENT DATA	<b>NAME:</b> LAST FIRST MI			
	NICKNAME:		PETS, HOBBIES:	
	MAILING ADDRESS: STREET OR BOX #			
	CITY		STATE	ZIP
	FATHER'S NAME:		SS#	MARITAL S M SP D RM W
			DL#	STATUS: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	OCCUPATION:	PLACE OF BUSINESS:	WORK PHONE: ( )	HOME PHONE: ( )
	MOTHER'S NAME:		SS#	MARITAL S M SP D RM W
			DL#	STATUS: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	OCCUPATION:	PLACE OF BUSINESS:	WORK PHONE: ( )	HOME PHONE: ( )
	LEGAL GUARDIAN (if other than parent):		SS#	MARITAL S M SP D RM W
			DL#	STATUS: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	OCCUPATION:	PLACE OF BUSINESS:	WORK PHONE: ( )	HOME PHONE: ( )
TO BE NOTIFIED IN EMERGENCY:		WORK PHONE: ( )	HOME PHONE: ( )	
DENTAL INSURANCE CARRIER:		GROUP NUMBER:		

Why have you brought your child to see the dentist?

Source of Introduction:

- |   |                                     |                                    |                                 |
|---|-------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> School examination | <input type="checkbox"/> Phone book | <input type="checkbox"/> Physician | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Relative           | <input type="checkbox"/> Patient    | <input type="checkbox"/> Dentist   |                                 |

1. Is this your child's first visit to a dentist? Yes  No

2. If no, give date of last examination: \_\_\_\_\_ Dentist's Name: \_\_\_\_\_

Were x-rays taken? Yes  No

3. Has your child ever had any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Tooth abscess (gum boil)    | <input type="checkbox"/> Frequent sore throats              | <input type="checkbox"/> Bad breath    |
| <input type="checkbox"/> Cold sores (fever blisters) | <input type="checkbox"/> Clicking, popping, or pain in jaws | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Injury to teeth             | <input type="checkbox"/> Toothaches                         | <input type="checkbox"/> Bleeding gums |

4. Does or did your child have habits which might affect oral health? If yes, check:

- |  |  |                                   |                                |
|--|--|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Clenching or grinding teeth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Pacifier | <input type="checkbox"/> Other |
| <input type="checkbox"/> Finger or thumb habits      | <input type="checkbox"/> Lip             | <input type="checkbox"/> Tongue   |                                |

5. Is your child presently nursing or drinking from a bottle? Yes  No

If no, when did they stop? \_\_\_\_\_ Usual contents in bottle: \_\_\_\_\_

6. Is fluoride taken in:

- |                                   |                                       |                                |                                    |
|-----------------------------------|---------------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Water    | <input type="checkbox"/> Toothpaste   | <input type="checkbox"/> Pills | <input type="checkbox"/> Not taken |
| <input type="checkbox"/> Vitamins | <input type="checkbox"/> Liquid rinse | <input type="checkbox"/> Gel   |                                    |

**PEDIATRIC INFORMATION**

## PEDIATRIC HEALTH HISTORY

1. Does your child have any health problems? Yes  No   
If yes, explain. \_\_\_\_\_
2. Were difficulties encountered during pregnancy or delivery of this child? Yes  No   
If yes, explain. \_\_\_\_\_
3. Did your child have a history of health problems at birth or during the initial years? Yes  No   
If yes, explain which years. \_\_\_\_\_
4. Is your child taking any medication or drugs at this time? Yes  No   
Please list: \_\_\_\_\_
5. Has your child ever had an unfavorable reaction to foods, drugs (Penicillin, Codeine)  
Or other medicines Yes  No   
Please list: \_\_\_\_\_
6. Has your child ever been hospitalized or seriously injured? Yes  No   
Date and reason: \_\_\_\_\_
7. Does your child have any limitations in sports activities? Yes  No   
If yes, explain. \_\_\_\_\_
8. Has your child had any history of the following?
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Kidney / liver problems             | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Breathing or lung problems          | <input type="checkbox"/> Blood transfusion     |
| <input type="checkbox"/> Blood disorders                   | (sickle cell anemia)   | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Hepatitis (other family members?) | <input type="checkbox"/> Rheumatic fever                     |  |
| <input type="checkbox"/> Heart trouble / murmur            | <input type="checkbox"/> Mental / emotional problems         |  |
| <input type="checkbox"/> Growth problems                   | <input type="checkbox"/> Hemophilia or other blood disorders |  |
- Comments: \_\_\_\_\_
9. Date and reason of last medical examination: \_\_\_\_\_
10. Do you think your child will be a cooperative patient? Yes  No
11. Is there additional information or comments we should know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Name of pediatrician or family physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

My signature below indicates that I understand and have answered all questions on the medical and dental health history to the best of my knowledge.

I request and freely consent to the performance of any additional tests or procedures which are deemed necessary after a complete clinical examination.

I have been informed that these procedures will be discussed with me prior to their taking place.

Signature (parent or guardian) \_\_\_\_\_ Date: \_\_\_\_\_

