

Confidential Medical History
St. Johnsbury Dental Associates, Inc.

Date: _____

To Parent or Guardian:

The following information is requested to enable us to provide a most appropriate level of care. This information, important for our records and for the child's health is, of course, confidential. Please fill in the following completely.

Child's Name: _____ Nickname: _____ DOB: _____ SS # _____

School now attending: _____ Grade: _____ Age: _____

Father's full name and address: _____

Mother's full name and address: _____

Father employed by: _____ Business phone: _____ Home phone: _____

Mother employed by: _____ Business phone: _____ Home phone: _____

Person financially responsible for this account: _____ Relationship to this child: _____

Dental Insurance: _____ Insured person's SS #: _____ Medicaid: _____

Child's favorite person(s): _____ Favorite fiction character: _____

Patient referred by: _____

Why is your child here today? _____

Date of last dental cleaning: _____ Name of previous dentist: _____

Is your child having any discomfort/pain? (describe) _____

Has your child had any unfavorable dental experiences? (describe) _____

Has your child ever had any injuries to mouth-teeth-head? (describe) _____

Any oral habits:	yes	no	Did your child ever sleep with a bottle? Yes No
thumb sucking	<input type="checkbox"/>	<input type="checkbox"/>	If so, what did the bottle contain? _____
finger sucking	<input type="checkbox"/>	<input type="checkbox"/>	At what age was the bottle stopped? _____
nail biting	<input type="checkbox"/>	<input type="checkbox"/>	Was your child breast fed? Yes No
mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	At what age was breast feeding stopped? _____
pacifier	<input type="checkbox"/>	<input type="checkbox"/>	Does your child brush his/her own teeth? Yes No
lip sucking	<input type="checkbox"/>	<input type="checkbox"/>	If so, when? _____
grinding of teeth	<input type="checkbox"/>	<input type="checkbox"/>	If not, by whom/when? _____

Is your water supply fluoridated? _____ Is dental floss used? _____ How often? _____

Does your child take fluoride supplements? Yes No Name of fluoride: _____

Has anyone recommended that your child see an orthodontist for braces? Yes No

Has your child had any teeth removed for orthodontic reasons? Yes No

Please Turn Page Over ➡

Physician's name: _____

Yes No

Has your child had a history of any of the following:

1. Is your child presently under the care of a physician Yes No

2. Is your child presently taking any medications? Yes No

If so, what: _____

3. Has your child ever been hospitalized? Yes No

If so, for what reason: _____

4. Has your child ever had an operation? Yes No

5. Is there any known allergy to medications? Yes No

If so, please name: _____

6. Is there any know food or other allergy? Yes No

If so, please name: _____

7. Are immunizations up to date? Yes No

Last tetanus shot or booster _____

8. Is there any family history of:

Bleeding disorder Yes No

Diabetes Yes No

Heart disease Yes No

Hepatitis Yes No

Latex allergies, such as balloons Yes No

1. Has anyone in your family been told they are a carrier of a disease (i.e. hepatitis)? _____

2. Has anyone in your family been told they are a carrier of HIV? _____

3. Have you or your spouse ever been treated for a drug related problem? _____

4. Have you or your child ever had a lingering illness? _____

5. Are there any other mental or physical problems you would like to discuss with me personally? _____

To the best of my knowledge, all the preceding answers are true and correct. I understand that my child's personal physician may be contacted if there are questions or concerns about this medical history. If my child's health or conditions change, I will inform the dentist at the next appointment without fail.

Signature of parent or guardian: _____

- | | Yes | No |
|--------------------------|--------------------------|--------------------------|
| Anemia or blood disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth defects | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathing difficulty | <input type="checkbox"/> | <input type="checkbox"/> |
| Broken bones | <input type="checkbox"/> | <input type="checkbox"/> |
| Cerebral palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Chicken pox | <input type="checkbox"/> | <input type="checkbox"/> |
| Cleft Lip or Palate | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting or dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart defect or murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis/Liver disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental retardation | <input type="checkbox"/> | <input type="checkbox"/> |
| Mononucleosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | |
| _____ | | |
| _____ | | |