



Fill out and print the form below and bring it with you for your first visit.

PATIENT'S NAME _____
Last First date of birth

Gender: M or F

PARENT'S/GUARDIAN'S NAME _____

MEDICAL HISTORY

- 1. Does your child have any health problem? YES NO
- 2. Has your child been diagnosed with any medical conditions? YES NO
If yes, please state the conditions: _____
- 3. **Name of your child's pediatrician** _____ Phone # _____
- 4. Is your child receiving any medication? YES NO
If yes, please list the medications: _____
- 5. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
If yes, please list the allergies: _____
- 6. Is your child allergic to or sensitive to any metals or latex? YES NO
- 7. Has your child ever had surgery? YES NO
If yes, please list the type of surgery and date: _____
- 8. Does your child have a heart murmur? YES NO
- 9. Does your child experience severe or prolonged bleeding? YES NO
- 10. Does your child have any blood borne diseases? YES NO
If yes, please list: _____
- 11. Does your child have any seizure disorders? YES NO
- 12. Does your child have asthma? YES NO
- 13. Has your child had history of: (Circle appropriate responses) ADHD, asthma, autism, bronchitis, cancer, cerebral palsy, congenital birth defects, diabetes, down syndrome, epilepsy, eye sight problems, hearing loss, heart condition, mental retardation, pneumonia, rheumatic fever, speech impairments.
- 14. Additional comments _____

COMMENTS

DENTAL HISTORY

- 1. Is this your child's first visit to a dentist? YES NO
- 2. If not, how long since the last visit to the dentist? _____
- 3. The main reason for dental visit today is for? _____
- 5. When was the child weaned off the bottle? _____
- 6. Who does the brushing? __ Child __ Parent/Guardian
- 7. Does your child floss? YES NO
- 8. Does your child receive Fluoride? YES NO
- 9. Does your child have any habits? (check all that is appropriate)
__ Thumb Sucking __ pacifier __Teeth Grinding __Other
- 10. Has there been any history of dental trauma? YES NO
- 11. Has anyone in the family, including parents, had orthodontics? YES NO
- 12. Does your child think there is anything wrong with his/her teeth? YES NO
- 13. My child is __excited __indifferent __nervous __scared to see the dentist today.
- 14. List some things that your child enjoys _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

DENTAL/MEDICAL HISTORY