

MEDICAL AND DENTAL HISTORY

Child's Name _____ Birthday ____ / ____ / ____ Male or Female

Primary Care Physician's name, address and phone number:

Please check all of the conditions that apply to your child:

- | | | |
|--------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnea/Snoring |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Speech/Hearing |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cerebral Palsey | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Hyperactivity/ADHD | |

Please list all other conditions that apply to your child: _____

Has your child ever been hospitalized? (Y / N) Please explain: _____

Please list all medications that your child takes regularly: _____

Please list all allergies and/or drug sensitivities that apply to your child: _____

What is the reason for your child's dental visit today? _____

When was your child's last visit to the dentist (if to a different office)? _____

Prior Dentist's name and phone number: _____

How do you think your child will react to this dental visit? (Circle one) Cooperative/ Uncooperative/ Not sure

How frequently does your child get his/her teeth brushed? (Circle one) 3 x day/ 2 x day/ 1 x day/ Seldom

How frequently does your child get his/her teeth flossed? (Circle one) 1 x day/ 1 x week/ 1 x month/ Never

Has your child ever injured his/her face/mouth/ teeth? (Y / N) Please explain: _____

Please list some of your child's interests/hobbies _____

Please state any other questions, comments or concerns _____

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AUTHORIZATION

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. I understand that any change in my child's health or medications requires that an updated medical/dental history form be completed.

I understand that by typing my name below, I am signing this document.

Parent or Legal Guardian

Date