Medical History

Date: ____________________________

Patient's Name ____ Age ______ Sex ______

Date of Birth ___________________________ Grade _______ School ___________________________________

Address ____ City ____________________ State _____ Zip ________

Father's Full Name ____ Birthdate ________________

Father Employed By ____ Social Security No. ___________________

Father's Home Phone ________________ Work Phone_______________ Email Address ___________________

Mother's Full Name ____ Birthdate ________________

Mother Employed By ____ Social Security No. ___________________

Mother's Home Phone _______________ Work Phone_______________ Email Address ____________________

Marital Status of Parents _____ Married _____ Separated _____ Divorced _____ Other ___________________

Name and number of nearest relative not living with you ____

____

Whom may we thank for referring you to our office? ____

Do you currently have Dental Insurance? ____

Insurance Company ____

Address ____ Phone ______________________

Policy Holder _________________________________ Employer ID# ________________ Group# _____________

PAYMENT OF PROFESSIONAL FEES: Payment for dental services in this office will be cash, check, Visa, MasterCard and Care Credit. Co-payment is DUE THE DAY that services are rendered. Portions of the bill not covered by insurance are the responsibility of the parent or guardian. Medicaid recipients must present a current Medicaid Card on the day of the visit. I understand and agree to these terms.

Date _______________________________ Signature ____

Has your child ever had or been treated by a physician for: (check only those that apply)

(CHECK)
_______ Hearing problems
_______ Eye problems
_______ Skin problems
_______ Tonsil/adenoid problems
_______ Sleep problems
_______ Emotional/behavior problems
_______ Attention deficit disorder
_______ Hepatitis
_______ AIDS or HIV+
_______ Cleft lip/Palate

(CHECK)
_______ Problems at birth
_______ Heart murmur
_______ Heart disease
_______ Rheumatic fever
_______ Anemia
_______ Sickle Cell Anemia
_______ Bleeding/Hemophilia
_______ Blood transfusion
_______ Kidney disease
_______ Speech problems

(CHECK)
_______ Cancer
_______ Cerebral Palsy
_______ Seizures
_______ Autism
_______ Diabetes
_______ Asthma
_______ Arthritis
_______ Liver disease
_______ Tuberculosis

If your child taking any medications at this time? ____

If so what? ____

Allergies (Please list) ____

Dental History

What is your main concern about your child's dental health? ____

____

Has your child been to a dentist before? _____ Yes _____ No, If yes, date of last visit ________________________

Date of X-rays ____

Former dentist's name ____

Reason for leaving former dentist ____

(CHECK ONE)

Yes	No	
______	______	Has your child experienced an unusual reaction to dental medication or anesthetic? If yes, explain.
______	______	Has your child experienced prolonged bleeding following dental treatment? If yes, explain.
______	______	Will your child be uncooperative? If yes, explain.
______	______	Has your child experienced any complications following dental treatment? If so, explain.
______	______	Has your child inherited any family facial or dental characteristics? If yes, explain.
______	______	Has your child had any injury to the teeth, jaws or face? If yes, explain.
______	______	Has your child had any clicking or pain in the jaw joints? If yes, explain.
______	______	Was your child breast fed? When stopped? ___________________________________
______	______	Was your child bottle fed? When stopped? ___________________________________
______	______	Did your child us a pacifier? When stopped? _________________________________
______	______	Did your child suck a finger or thumb? When stopped? __________________________
______	______	Does your child brush his/her own teeth?
______	______	Does your child use dental floss?
______	______	Do you usually help your child brush?
______	______	Do your child's gums bleed when brushed?
______	______	Did you or your child ever get instructions in brushing?
______	______	Does your child use fluoride products: rinses, drops, tabs?

☐ Cavities	☐ Color of teeth	☐ Teeth sensitive to hot or cold	☐ Bleeding gums
☐ Tooth aches	☐ Gum infection	☐ Teeth sensitive to sweets	☐ Appearance of teeth
☐ Teeth bumped	☐ Grinds teeth	☐ Other dental problems	

Explanations and comments:

____

____

____

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

PERSON COMPLETING THIS FORM: Signature ____________________________________ Date ___________

Relationship to patient ____