CHILD'S MEDICAL HISTORY

PATIENT INFORMATION

Patient's Last Name:_____First:_____Middle Initial:__
Address:_____
Street City Postal Code
Birthday: _____ Sex(M/F):___Phone(Best Contact):_____Email(Best Contact):_____
Parent/Guardian Full Name:_____Phone(Cell)_____
Parent/Guardian (Full Name):_____ _____Phone(Cell)_____
Whom May We Thank For Your Referral To Our Office:_____
Dental Insurance Carrier(Primary):_____Group#:_____Policy#:_____
Dental Insurance Carrier(Secondary):_____Group#:_____Policy#:_____
EmergencyContact:_____Phone:_____Relationship:_____

DENTAL INFORMATION

Has your child seen a dentist before this visit? ___
When was your child's last dental visit?_____Did your child visit the dentist regularly?_____
Were there problems of any kind in the previous office? ___
Date of the most recent x-rays:_____How often does your child brush his/her teeth?____ Has your child had any Orthodontic work or been advised of the need for this treatment? Yes Does your child have a history of thumb, finger or pacifier sucking? ___
Does your child clench or grind his/her teeth? _____

MEDICAL HISTORY

Does your child have any current health problems? (List if any)_____
Is your child currently under the care of a physician? ____
Has your child ever been hospitalized or treated for any medical condition? ____
Is your child currently taking any medication?
(List)_____
Has your child ever had a bad reaction or allergies to any medications or anaesthetic?_____
Name of Physician:_____Address:_____Phone:_____

PLEASE CHECK ANY OF THE CONDITIONS WHICH MAY APPLY TO YOUR CHILD

___Heart Disease	___Anemia	___Lung Disease	___Thyroid Condition
___Hepatitis: A, B, or C	___Rheumatic Fever	___Mitral Valve Prolapse	___Cancer
___Epilepsy	___Diabetes	___Asthma, Shortness of Breath	
___Bruises easily	___HIV positive (AIDS)	___Heart murmur or Artificial Valve	
___Faints or have dizzy spells			

Is there anything else about your child's health not already discussed?_____
_____

I understand that the above questions directly relate to the quality of care I can expect my child to receive in this office, and I have not knowingly withheld information that could complicate my child's treatment.

Parent's or Guardian's signature: _____Date:_____