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:

( )Anemia	( )Asthma	( )Autism	( )Birth Defects
( )Bleeding Problems	( )Blood Disorders	( )Cancer	( )Cerebral Palsey
( )Diabetes	( )Down Syndrome	( )Epilepsy/Seizures	( )Emotional Problems
( )Heart Condition	( )Heart Murmur	( )Hepatitis	( )HIV/AIDS
( )Liver Disease	( )Learning Disabilities	( )Kidney Disease	( )Hyperactivity/ADHD
( ) Intellectual Disability	( )Rheumatic Fever	( )Skin Disorders	( )Psychiatric Problems
( )Sleep Apnea/Snoring	( )Spina Bifida	( )Tuberculosis	( )Speech/Hearing

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 (Circle one) Please explain: _____

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

Please state any other questions, comments or concerns _____

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.

_____

Parent or Legal Guardian Date