Dental and Medical History

Patient Name: Birth Date: Date Created:

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives.

How often does your child brush?

How often does your child floss?

Is your child's water fluoridated? ○ Yes ○ No

Does Your Child...

☐ Suck thumb or finger	☐ Suck/Bite lip	☐ Bite/Chew nails
☐ Chews hard objects (ice, etc)	☐ Grind teeth	☐ Clench Jaws

Dental History

Previous Dentist (Please add name, address and phone #) ○ Yes ○ No

Date of last dental visit

What was it for

Has your child had difficulty with previous dental visit ○ Yes ○ No If yes

Medical History

Child's physician (Please add name, address and phone #) ○ Yes ○ No

Health Information

Previous Hospitalizations/Surgeries/Illness ○ Yes ○ No If yes

Is your child currently taking medications? (If yes please list) ○ Yes ○ No

Has your child ever taken Fenphen/Redux? ○ Yes ○ No

Does your child have a history of allergies to:

☐ Penicillin	☐ Novocaine	☐ Latex	☐ Food
☐ Environmental			

Other

Has your child ever had any of the following?

☐ Asthma	☐ Cancer	☐ Hepatits	☐ HIV / Aids
☐ Hemophilia	☐ Abnormal Bleeding	☐ Congenital Heart Defect	☐ Acid Reflux
☐ Autism/ Down Syndrome	☐ ADHD/ADD/COD	☐ Stomach/Liver/Kidney Problems	☐ Handicaps/Disabilities
☐ Tuberculosis	☐ Diabetes	☐ Rheumatic Fever	☐ Heart Mumur
☐ Convulsion/Epilepsy	☐ Osteoporosis	☐ Bipolar/Nervous System Disorde	☐ Speech Development Delay

Other Medical Problems (if yes, please explain) ○ Yes ○ No If yes

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

It is my responsibility to inform the dental office of any changes in my childs medical status. I also authorize the dental staff to perform the necessary dental service my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Print Name (Name of Parent or Guardian) _____

Signature of Patient, Parent or Guardian: