PATIENT HISTORY UPDATE

Child's Name_____ Date of Birth_____ Today's Date _____

Home Address_____ City_____ State_____ Zip_____

Mother's Name_____ Social Security #_____

Home Phone #_____ Cell #_____ Email_____

Home Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____ Phone #_____

Father's Name_____ Social Security #_____

Home Phone #_____ Cell #_____ Email_____

Home Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____ Phone #_____

Dental Insurance

Subscriber_____ Date of Birth_____

Group/Policy #_____ Insurance Carrier and Phone #_____

Child's Physician_____ Address _____ Phone #_____

Is a physician treating your child now for a specific illness? ..... YES NO
If so, for what reason? _____
Is your child taking any medications? (including over-the-counter medications, vitamins, herbal supplements) YES NO

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions to any of the following?

a) Medications or drugs_____
b) Foods_____
c) Other_____

Did your child have any problems with the birth or pregnancy? ..... YES NO
Was your child hospitalized for a period longer than normal after birth?..... YES NO
Why? _____
Has your child ever been hospitalized?..... YES NO
When? _____
For what reason? _____
Has your child had any operations or surgeries? ..... YES NO
When? _____
For what reason? _____
Does your child have any psychological or emotional problems you would like to bring to our attention? ..... YES NO
Please describe: _____

Does your child have any history of the following diseases or conditions? (Please **check** all that apply)

□ Autism
□ ADD/ADHD
□ AIDS/HIV+
□ Asthma or Lung Problems
□ Blood/Clotting Disorders
□ Blood Transfusions
□ Cancer/Tumors
□ Celiac Disease
□ Cerebral Palsy
□ Cleft Lip/Palate
□ Developmental Delay
□ Diabetes
□ Down Syndrome
□ Headaches
□ Heart Murmurs/Congenital Heart Disease
□ Intellectual Disability
□ Kidney/Bladder Problems
□ Liver Problems, Jaundice, Hepatitis
□ Lyme Disease
□ Psychological/Mood Disorders
□ Seizures, Epilepsy
□ Severe Infections
□ Speech/Hearing Disorder
□ Thyroid Disease
□ Other, If so explain_____

Does your child have any of the following habits? (Please **check** all that apply)
□ Pacifier □ Thumb/Finger Sucking □ Tongue Thrusting □ Lip Sucking/Biting
□ Grinds Teeth □ Mouth Breathing □ Bottle to bed- If so, what's in the bottle_____
□ Other_____

Fluoride: (please **circle**)
What type of water do you have at your home? Well Public
Do you have fluoride in your water? Yes No Don't Know
If no, does your child take a fluoride supplement - drops or tablets? Yes No Don't Know
Toothpaste Type and Brand_____

Comments or Concerns_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. If there are any changes, or omissions to the patient's medical history, it is my responsibility to inform the dental office before treatment begins.

Parent/Guardian Signature_____ Relationship_____ Date_____
Doctor Signature_____ Date_____

FOR OFFICE USE ONLY

MEDICAL

DENTAL

Update 2018