PERSONAL **PATIENT HISTORY** DATE ____________

Child's Name ______________ (First) ______________ (Middle) ______________ (Last) Nickname (if any) ____________

Date of Birth ____________ Age ____ Sex: M F School ____________ Grade ____

Home Address ____________ City ____________ State ______ Zip ______

Name and Age of Siblings ____________

Interests or hobbies: ____________

Parent's Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Mother's Name ____________ Social Security # ____________

Home Phone # ____________ Cell # ____________ email: ____________

Home Address ____________ City ____________ State ______ Zip ______

Employer ____________ Occupation ____________ Bus. Phone # ____________

Business Address ____________ City ____________ State ______ Zip ______

Father's Name ____________ Social Security # ____________

Home Phone # ____________ Cell # ____________ email: ____________

Home Address ____________ City ____________ State ______ Zip ______

Employer ____________ Occupation ____________ Bus. Phone # ____________

Business Address ____________ City ____________ State ______ Zip ______

Whom May We Thank for Referring You? ____________

HEALTH INSURANCE INFORMATION

Dental Coverage ☐	Medical Coverage
Subscriber (covered employee) ____________	Subscriber (covered employee) ____________
Date of Birth ____________	Date of Birth ____________
Employer providing insurance: ____________	Employer providing insurance: ____________
Name of insurance carrier (company): ____________	Name of insurance carrier (company): ____________
Group or Policy # ____________	Group or Policy # ____________

MEDICAL HISTORY

Child's Physician ____________ Address ____________ Phone # ____________

Date of last physical examination? ____________ Results ____________

Is a physician treating your child now for a specific illness? . . . . Yes No

If so, for what reason? ____________

Is your child taking any medication at this time? (including over-the-counter medications, vitamins, herbal supplements) . . . . . Yes No

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions?

a) Medications or drugs ____________

b) Foods ____________

c) Other ____________

Were there 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? If so, ... Yes No

When? ____________

For what reason? ____________

Has your child had any operations? If so, ... Yes No

When? ____________

For what reason? ____________

Are there any psychological or emotional problems you would like to bring to our attention? . . . . Yes No

Does your child have any history of the following diseases or conditions?

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

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION THE DENTIST SHOULD BE AWARE OF, OR THAT HAS NOT BEEN COVERED ABOVE.

____

DENTAL HISTORY

Why did you make this appointment? ____

Is this your child's first visit to a dentist? Yes No

If not, how long since the last dental visit? ____

Child's previous dentist:

Name ____

Address ____

Approximate date of last dental "x-rays" ____

Has your child ever had any unpleasant dental experience? Yes No

If so, please explain: ____

Does your child have any of the following habits? (indicate ages when occurred)

Bottle to bed at night or nap ____

What was in bottle? ____

Use a pacifier? ____

Thumb or finger sucking ____

Tongue thrusting ____

Lip sucking or biting ____

Mouth breathing ____

Grinds Teeth ____

Does your child brush his/her own teeth? . . . . Yes No
How frequently and when? ____

Do you brush your child's teeth? . . . . Yes No
How frequently and when? ____

Do you or your child use dental floss in cleaning your child's teeth? . . . . Yes No
How frequently and when? ____

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 ____

Have your child's teeth ever been injured? . . . . Yes No
When? ____
Which Teeth? ____
Cause? ____
Were the teeth treated? . . . . Yes No
If so describe treatment ____

Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? . . . . Yes No

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.

Signature ____ Relationship ____ Date ____

SUMMARY: (FOR DOCTOR'S USE) REVIEWER: ____ DATE: ____

MEDICAL

DENTAL