Child's Information

Last Name		First		MI		Nickname	
Date of Birth		SSN		Age		Sex:	M F
Address		City		State		Zip	
Father Name		Cell Phone				Email	
		SSN				DOB	
Mother Name		Cell Phone				Email	
		SSN				DOB	

Does child attend daycare/preschool/school: Y N Grade ______ Where ______

Custodial Parent's Name: ______

Names of other family members seen in our office ______

Who does child live with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:

Medical History

Has your child ever had any of the following: (please circle)

Condition			Condition		
Abnormal Bleeding / Bruising	Y	N	Hearing Problems	Y	N
Attention Deficit Disorder (ADD/ADHD)	Y	N	Hemophilia	Y	N
AIDS/ HIV	Y	N	Hepatitis	Y	N
Anemia	Y	N	Heart Murmur	Y	N
Asthma	Y	N	Heart Condition (new or repaired)	Y	N
Autism Spectrum Disorder	Y	N	Kidney Disease	Y	N
Autoimmune Disorder	Y	N	Latex Allergy	Y	N
Bladder	Y	N	Learning Disability	Y	N
Cancer	Y	N	Liver Disease	Y	N
Cerebral Palsy	Y	N	Measles	Y	N
Chemotherapy	Y	N	Mononucleosis	Y	N
Chicken Pox	Y	N	Mumps	Y	N
Chronic Sinus	Y	N	Pregnancy or Possible Pregnancy	Y	N
Cleft Lip/Palate	Y	N	Rheumatic Fever	Y	N
Congenital Heart Defect	Y	N	Seizure Disorder / Epilepsy	Y	N
Convulsions	Y	N	Sickle Cell Anemia/ Trait	Y	N
Diabetes ☐ Type I ☐ Type II	Y	N	Sleep Disorders	Y	N
Down's Syndrome	Y	N	Speech Problems	Y	N
Eating Disorder	Y	N	Traumatic Brain Injury	Y	N
Emotional Issues	Y	N	Thyroid Disease	Y	N
Epilepsy	Y	N	Tuberculosis	Y	N
Fainting	Y	N	Tumors	Y	N
Gastric Tube (G-Tube)	Y	N	Venereal Disease	Y	N
GERD Gastroesophageal Reflux Disease	Y	N	Visual Impairment	Y	N
Genetic Disorders	Y	N	Other:	Y	N

Signature of Patient, parent or guardian ______ Date ______

Signature of Dentist ______ Date ______

Medical History (cont.)

Child's Physician ______________________ Physician's Address ______________________

Physician's Phone ______________________ Date of last examination ______________________

Is your child allergic to any of the following: ☐ Latex ☐ Pain Medications ☐ Penicillin ☐ Metal ☐ Local Anesthetics ☐ Other:

Does your child have any other allergies: ☐ Food ☐ Dust ☐ Animals ☐ Pollen ☐ Other:

1. Does your child require a pre-medication for cleaning? Y N
2. Is the child's Immunizations up to date? Y N
3. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? Y N

   If yes, please list the name, dosage and frequency of each: ______________________

4. Has the child ever had a serious illness? If yes, please explain: ______________________ Y N
5. Has the child ever been hospitalized? If yes, please explain: ______________________ Y N
6. Has the child ever had surgery or been put to sleep? Y N

   If yes, please list any problems with general anesthesia: ______________________

7. Is the child currently under the care of any special care doctors (heart, neuro, gastro, etc.)? If yes, please provide the Doctor's name, specialty, and contact phone number: ______________________ Y N
8. Is the child physically, mentally or emotionally impaired? If yes, please explain: ______________________ Y N
9. Does the child experience excessive bleeding when cut? Y N

Dental History

Date of patient's last visit ______________________ For what service: ______________________

Were X-rays taken? ______________________ Name of Dentist ______________________

Does patient brush daily? Y N Use floss daily? Y N

Has the patient had any unhappy dental experiences? Y N

What is your child's attitude toward dentistry? ______________________

Any injuries to mouth/teeth/head? If yes, please describe: ______________________ Y N

Any mouth habits: ☐ Thumbsucking ☐ Nail biting ☐ Mouth breathing ☐ Nursing bottle habits ☐ Pacifier ☐ N/A

Has the child complained about any dental problems? Y N

What type of water is used? ☐ City Water ☐ Well Water ☐ Bottled Water

If currently nursing: ☐ Breast-Fed or ☐ Bottle-Fed

Any additional information that you may think is valuable to us? ______________________

We L💙VE Referals! How did you hear about us:

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 medical status.

Signature of Patient, parent or guardian ______________________ Date ____________

Signature of Dentist ______________________ Date ____________