
MEDICAL HISTORY

PATIENT INFORMATION

Patient Name _____ Birth Date _____ SSN _____
Name your child wishes to be called _____ Sex F M Age _____
Address _____ Home Phone _____
Child's School _____ Grade _____
Siblings _____

FAMILY INFORMATION

Have any members of your family been seen in our office? _____

Mother's Name : _____ Birth Date _____ SSN _____
Address _____ Home Phone _____
Cell Phone _____
Employer _____
Email: _____ Employer Phone _____
Father's Name _____ Birth Date _____ SSN _____
Address _____ Home Phone _____
Cell Phone _____
Employer _____
Email: _____ Employer Phone _____
Child resides with: Mother Father Both Parents other _____
Address _____ Home Phone _____
Employer _____
Employer Phone _____

Person responsible for payment on account _____

Note: If a person is not specified above, the person who brings the child to their initial visit will be listed as the Guarantor on the account. All correspondence will be addressed and mailed to the person listed as the Guarantor. If a family member is already listed in our system we will add the patient to the existing account unless we are instructed otherwise

HEALTH HISTORY

Who is your child's pediatrician/medical doctor? _____ Phone _____
Has your child ever been hospitalized? Yes No
If so, give reason. _____
Does your child have any allergies to medications or substances? Yes No
If so, please list. _____
Does your child have any other allergies? Yes No
Is your child currently taking any medications or substances? Yes No
If so, please list. _____

Does your child have or has your child ever had any of the following?

Rheumatic Fever	Yes	No	Leukemia	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	Heart Murmur	Yes	No	AIDS	Yes	No
Anemia	Yes	No	HIV Positive	Yes	No	Hemophilia	Yes	No
Hepatitis	Yes	No	Asthma	Yes	No	Tuberculosis	Yes	No
Epilepsy	Yes	No	Cleft Lip/Palate	Yes	No	Other Seizures	Yes	No

Please describe any of the above conditions that you have stated "yes" to:

Does your child have any disease, condition or problem not listed?

DENTAL HISTORY

Has your child ever been to the dentist? Yes No Name and date _____
How long since last visit? _____
Does your child suck a finger, thumb or pacifier? Yes No
How often does your child brush their teeth? _____
Are you aware of any particular problems? _____

How do you feel about your child's teeth in general? _____

Comments: _____

FLOURIDE HISTORY

Do you have city water? Yes No If No, what is your source of water: _____
Does your child use fluoride toothpaste? Yes No
Do you give your child any other form of fluoride? Yes No What type _____
Does your child participate in a school fluoride rinse program? Yes No

Would you like to speak to the dentist privately about any problem? Yes No

In regards to the learning process, do you consider your child: advanced progressing normally slow

Was your child: breast fed bottle fed both at what age was it stopped? _____

I certify that the above information is complete and accurate to the best of my knowledge.

Parent/Guardian's Signature _____
