

Medical & Dental History Form

Patient Name

Last	First	MI	Preferred

Sex

Male Female

Date of Birth: _____

Person Responsible for Account

Relationship to Patient

Your child's overall health as well as any medications that your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Pediatrician's name: _____

Address: _____

Phone number: _____

What is the date (or approximate date) of your child's last pediatrician visit? _____

Within the past year, have there been any changes to your child's general health?

Yes No

Has your child ever had any of the following diseases or medical problems?

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> ADHD | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Congenital Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug/Alcohol Dependency |
| <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease | |

Does your child need antibiotic premedication? If so, please list: _____

Yes No

Is your child currently being treated for any condition? If so, please explain:

Please list any medications your child is taking:

Any history of hospitalizations? If so, please explain: _____

Any history of surgery? If so, please explain: _____

Please explain any other medical problems and include any **drug allergies** that your child has:

Does your child currently have:

- Cold Virus Ear Infection Upper Respiratory Infection

Has your child ever been to a dentist: Yes No

If yes, when: _____

Where? _____

Has your child ever had any upsetting dental experiences? Please explain:

What is the primary reason for your visit today? _____

What are your expectations? _____

How would you describe your child:

- Friendly Shy Nervous
 Scared Strong-Willed Out-going

Who brushes your child's teeth? _____

How often?

- Twice a day Once a day 3-4 times a week Seldom

How frequently does your child floss?

- 1(+) a day 2-6 weekly 1-6 monthly Seldom Never

Does your child have any habits?

- Thumb/Finger Sucking Suck/Bit Lips Chewing Hard Objects
 Pacifier Grinding Teeth Nail Biting
 Clenching Jaw

Is there anything else you would like us to know about your child to make the visit even more special for them? Any special interests or hobbies?

(Please initial) To the best of my knowledge, all of the preceding information is true and correct. If any change occurs to my child's health, I will inform the office at the next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____

Reviewed by: _____ Date: _____