



**World of Smiles, Pediatric Dentistry**

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**Medical & Dental History Form**

Patient Name

Sex                      Last                      First                      MI                      Preferred  
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?  
Abnormal Bleeding                      ADHD                      Allergies  
Asthma                      Autism                      Cancer  
Congenital Heart Murmur                      Diabetes                      Drug/Alcohol Dependency  
Handicaps/Disabilities                      Hemophilia                      Hepatitis  
HIV/AIDS                      Rheumatic Fever                      Sinus Problems  
Tuberculosis                      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:  No  Yes

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: \_\_\_\_\_