# Medical and Dental History

Has your child ever had any of the following medical problems? If yes, circle and please explain.

| | | |
|---|---|---|
| ADD/ADHD | Cleft Lip/Palate | Lung Disorder |
| Allergies to Drugs/Latex | Congenital Heart Defect | Kidney/Liver Problems |
| Allergies to Foods | Convulsions/Epilepsy | Operations/Hospitalizations |
| Apraxia | Developmental Delay | Orthopedic Problems |
| Anemia | Diabetes | Respiratory Disease |
| Artificial Valves | Digestive Problems | Rheumatic Fever/Heart Disease |
| Asthma | Disabilities/Handicap | Scarlet Fever |
| Aspergers | Hearing Impairment | Seizures |
| Autism | Heart Condition | Sickle Cell Disease/Trait |
| Behavior Disorder | Heart Murmur | Skin Disorder |
| Abnormal Bleeding | Hemophilia | Speech Problems |
| Blood Disease | Hepatitis | Syndromes |
| Brain Surgery/Disorder | HIV/AIDS | Tuberculosis |
| Cancer/Tumors | Latex Allergy | Visual Impairment |
| Cerebral Palsy | Leukemia | OTHER |

Please explain any medical problems that your child has that is/is not listed above

____________________________________________________________

Is there any additional information that will help us treat your child today?____________________

____________________________________________________________

Who is your child's pediatrician/physician?______________ Phone number______________

Yes No Are your child's immunizations up to date?
Yes No Is your child in good health?
Yes No Have you ever been told your child needs antibiotics before dental treatment?
Yes No Is your child under the care of a physician for other than routine care? Please explain________________

____________________________________________________________

Yes No Does your child have any drug allergies or adverse reactions to any medications? Please list:____________

____________________________________________________________

Yes No Does your child have a history of allergies to any other substance (red dye, latex, etc)? Please list:__________

____________________________________________________________

Yes No Is your child taking any medications at this time, including over the counter and homeopathic medicines? Please list and explain what the medicine is for.________________________________________

____________________________________________________________

Yes No Has your child ever been hospitalized or treated in the emergency room? When and for what reasons:_______

____________________________________________________________

Yes No Does your child have any social, physical, growth, mental or emotional disorders? Please explain.__________

____________________________________________________________

Yes No Does your child or anyone in your family have a condition called methylenetetrahydrofolate reductase deficiency (MTHFR) or hyperhomocysteinemia?

## Dental History

What is the reason for today's visit?________________________________________

Yes No Has your child ever been seen by a dentist before? If yes, name and date______________________
Yes No Do you expect your child to be uncooperative?
Yes No Has your child ever had an unfavorable dental experience?
Yes No Have there been any injuries to your child's face, mouth or teeth?________________________
Yes No Does your child suck his/her thumb, finger(s), pacifier, blanket, bite nails, etc? (circle if yes)
Yes No Have your child's tonsils/adenoids been removed?
Yes No Does your child drink unfluoridated water? CIRCLE ONE City Water Bottle Water Filtered Water OTHER
Yes No Does your child take fluoride supplements?
Yes No Does your child eat toothpaste? CIRCLE ONE Toothpaste WITH Fluoride Toothpaste WITHOUT Fluoride

## Consent and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child ever has a change in health. All information will be held in the strictest of confidence. I authorize the dentist and dental staff to perform the necessary dental services my child may need and I am responsible for the cost of this treatment at the time of visit unless prior arrangements have been made. I further understand that this consent will remain in effect until such time that I choose it to be terminated.

Parent/Guardian signature______________________ Today's Date__________

PATIENT Name ________________male ____ female _____ Date of Birth__________

**Services rendered today are circled by us. Your initials authorizes each service.**

______ Cleaning/ ______ Exam/ ______ Fluoride/ ______ Bitewing(s)/ ______ PA(s) / ______ Occlusal(s)/ ______ Panoramic x-ray