

Patient's Name:		Nickname:	Date of Birth:
Parent's/Guardian's Name:		Relationship to Patient:	
Address: <small>PO Box or Mailing Address</small>		City	State Zip Code
Phone: () () <small>Home Work</small>		Sex: M <input type="checkbox"/> F <input type="checkbox"/> Non binary <input type="checkbox"/>	

Have you (the parent/guardian) or the patient had any of the following diseases or problems:
1. Active Tuberculosis 2. Persistent cough greater than a three-week duration 3. Cough that produces blood? Yes No
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or condition related to, any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Heart	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/ Joints	<input type="checkbox"/> Ear Aches		<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	

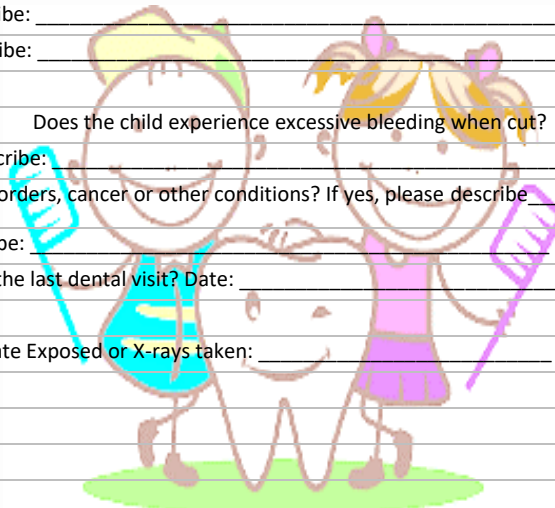
Autism Spectrum Disorder (ASD) Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Please list the name and phone number of the child's physician: Physician _____ Phone - -

Date of last physical exam: _____ Referred to our office by: _____

Child's History

		Yes	No
1.	Is the child currently taking any prescription and/or over the counter medications or vitamin supplements? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the child allergic to any medications, i.e. Penicillin, antibiotics, or other drugs? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the child currently pregnant? If yes, how many weeks? _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has your child ever been pregnant or had a baby? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, normal vaginal delivery? YES <input type="checkbox"/> NO <input type="checkbox"/> C-Section? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6.	Was the child's baby placed in NICU or PICU after delivery?	<input type="checkbox"/>	<input type="checkbox"/>
7.	How would you describe the child's eating habits?		
8.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has the child ever been hospitalized? If yes, when: _____ Please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	Does the child have a history of any other illnesses? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has the child ever received a general anesthetic If yes, please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does the child have any inherited problems? If yes, please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	Does the child have any speech difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Has the child ever had a blood transfusion? YES <input type="checkbox"/> NO <input type="checkbox"/> Does the child experience excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Is the child physically, mentally or emotionally impaired? If yes, please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	Has your child ever taken oral or intravenous bisphosphonates for bone disorders, cancer or other conditions? If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	Is the child currently being treated for any illnesses? If yes, please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	Is this the child's first visit to the dentist? If not, what was the date of the last dental visit? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	Has the child had any problem with dental treatment in the past?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Has the child ever had a dental radiographs (x-rays) exposed? If yes, Date Exposed or X-rays taken: _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	Has the child ever suffered any injuries to the mouth, head or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Has the child had any problems with the eruption or shedding of teeth?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Has the child had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Does the child suck on his/her thumb, fingers or pacifier?	<input type="checkbox"/>	<input type="checkbox"/>
25.	What type of water does your child drink? City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water <input type="checkbox"/>		
26.	Is fluoride toothpaste used? YES <input type="checkbox"/> NO <input type="checkbox"/> Does the child take fluoride supplements? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____		
28.	Do you floss your child's teeth? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, how often: _____		
29.	At what age did the child stop bottle feeding? Age: _____ Breastfeeding? Age: _____		
30.	What is the reason for your visit today?		
31.	How often does your child visit the dentist? _____ Name of former Dentist: _____		



Parent's/Guardian's Signature _____ Date _____

For Completion by dentist

Comments: _____

Please mark (x) if any apply: Medical Alert noted Premedication Required Allergies **Reviewed by:** _____ **Date:** _____