Date: ______________________

Patient Name: ____

Who is accompanying the child today?

Name: ____

Relationship: ____

Have there been any changes to your insurance?   Y / N

____

Are there any changes in address or phone numbers? Y / N

____

Health History: (**Please make sure to <u>circle</u> Y or N for all!!**)

Has your child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Pregnancy

Y N Tuberculosis

Y N ADD/ADHD

Y N Disabilities/Special Needs

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV +/ AIDS

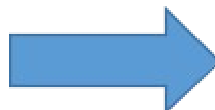
Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Diabetes

Y N Autism



Please discuss any serious medical conditions the child has had:

____

____

Please list all drugs that the child is currently taking: ____

Please list all the drugs that the child is allergic to: ____

Has the child had any injuries to the teeth, face or mouth? ________________________________

If yes, please explain: ____

Does the child have any of the following habits?

Y N Lip Sucking/Biting

Y N Nursing/Bottle Habits

Y N Nail Biting

Y N Thumb/Finger Sucking

Has the patient been experiencing any cold or flu like symptoms recently Y N

Has the patient had a fever in the last 48 hours Y N

<u>*PLEASE BE AWARE THAT WE PERFORM A FLUORIDE TREATMENT EVERY 6 MONTHS, & IT IS YOUR RESPONSIBILITY TO KNOW IF YOUR INSURANCE COVERS THIS PROCEDURE.*</u>

_______________________________________ _____________________________________

Signature of Parent or Guardian Date

______________________For Office use Only_____________________

I verbally reviewed the medical/dental information above with the Parent/Guardian and the patient named herein.

Initials___________ Date___________ Doctors Comments____________________________

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631-762-9910 l **www.longislandsmallsmiles.com**