Child/Adolescent Medical / Dental History

Date:_____
Patient's Full Name_____ Nickname_____
Why did the child come to the dentist today?_____
Home Address_____
City_____ Zip_____ Patient's Home telephone#_____
Date of Birth_____/_____/_____ Sex: M (__) F (__) Grade:_____ School _____
Social Security Number:_____— _____— _____E mail Address of parent (if any) _____
Do you have any other children? Yes (__) or No (__)
Names and Ages of your children (include this child)
1) _____ 2) _____
3) _____4) _____ 5) _____
Who is accompanying this child today?_____Relationship:_____
With whom does the child primarily reside?(__) Both parents (__) Mother (__) Father (__) Guardian (__) Other

Father's Information (_) Father (_) Stepfather (_) Guardian
Name:_____Date of Birth_____/_____/_____ S S N _____
Address_____City_____Zip_____HomeTelephone#_____
Occupation _____ Employer_____ Wk Phone#_____Cell# _____

Mother's Information (_)Mother (_) Stepmother (_) Guardian
Name:_____ Date of Birth_____/_____/_____ S S N_____
Address_____City_____Zip_____Home Telephone # _____
Occupation:_____ Employer _____Wk Phone#_____ Cell# _____
Whom may we thank for referring you?(___) Sign on building (___)Yellow Pages (___)Letter/ Newsletter sent to you
(___) Friend/ Family/ Employee: Name _____) (___) Other_____

Our dentist does not participate in any of the managed care dental plans (DMO's, PPO's). Traditional insurance is accepted and submitted on your behalf, but you are responsible for any charges your insurance does not cover at the time of service.

INSURANCE INFORMATION
Primary Insured Party's Full Name _____ _____Social Security Number _____
Relationship to Patient: (__) Parent (__)Step Parent (__) Other (specify_____)
Employer _ _____
Insurance Company Name _____
Ins. Address _____ Ins Phone # _____
Group or Union Name_____ Group or Local Number _____
Secondary Insured's Name _____ Social Security Number _____/_____/_____
Employer _____
Insurance company Name_____
Ins. Address _____ Ins Phone # _____
Special Notes _____

Pediatrician's Name _____City _____ State _____
Former Dentist's Name _____City_____ State _____
Why are you changing dentists? _____
Is this your child's first dental visit? (__) Y (__) N When was the last time your child had a check up and professional cleaning? _____x-rays? _____
Does your child drink (__) City water (__) Well water (unfluoridated)
Has your child had sealants placed on his/her permanent molars to prevent decay? (__) Y (__) N When?_____
_____
Has your child been to an orthodontist for an evaluation of his/ her bite? (__)Y (__) N
Is your child currently seeing an orthodontist? _____ If so, who? _____,
what city?_____
Is your child having pain today? Y (__) N (__) Please describe: _____
_____
Is your child apprehensive about dental treatment Y (__) N (__) If so , what is he / she apprehensive about ? _____
_____
Have you been told to give your child an antibiotic before dental treatment? Y(__) N (__)
For what condition does your child need to be premedicated with an antibiotic? _____
Do you brush your child's teeth or does your child brush his/ her own teeth? (__) Y (__) N _____
Has your child ever had any serious problems with previous dental work Y(__) N(__) Describe: _____
_____

Has your child ever had any of the following diseases or medical problems? Please Circle Y or N

Y N Congenital heart defect
Y N Heart murmur
Y N Cerebral Palsy
Y N Mitral valve prolapse
Y N Artificial bone /valve /joint
Y N Tourette Syndrome
Y N Hepatitis
Y N HIV + / AIDS / ARC
Y N Tuberculosis
Y N Drug/Alcohol abuse
Y N Mental Retardation

Y N Diabetes
Y N ADD/HDHD
Y N Psychiatric Treatment
Y N Anemia
Y N Blood transfusions
Y N Epilepsy or seizures
Y N Cortisone (steroid medicine)
Y N Growth disorder
Y N Handicaps/disabilities
Y N Any operations? (What?)
_____

Y N Sinus Trouble
Y N Rheumatic Fever
Y N Chemotherapy
Y N Radiation treatment
Y N Cancer (what kind?_____
Y N Bulimia
Y N Asthma
Y N Fever blisters
Y N Hemophilia
Y N Congenital defect

Is your child allergic to any of the following?

Y N Codeine Y N Dental Anesthetics Y N Penicillin Y N Erythromycin Y N Clindamycin

Please list any other drugs that your child is allergic to:_____
Please list all medications/herbs/over the counter drugs your child is taking and why he/she is taking them.
1.)_____for_____ 2)_____for_____
Please list any other medical condition or problem that your child has been treated or is being treated for:
_____

Does your child suck his/her thumb (or fingers) or pacifier (___) Y (___) N What _____

Could your child be pregnant or be taking birth control pills? (___) Y (___) N (___) Possibly

_____(initial) **Broken Appointments** – I understand that appointments changed without 24 hours notice are subject to a $50.00 per hour fee.

<u>Children will not be treated unless a parent is in the reception room or the child is over 18</u>

We do not allow adults in the treatment area while the child is being treated unless the child is under 5

I affirm that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical history. I understand I am responsible for any charges incurred at this office for providing dental care for my child.

_____Date_____
Signature of parent/guardian