Patient Medical History (8+ years)

GENERAL

Your/Child's Name: _____

Describe the primary concern with you/your child's teeth:_____

DENTAL

Does you/your child:

- o Yes o No Take Fluoride Supplements
- o Yes o No Bite lip
- o Yes o No Bite or chew nails
- o Yes o No Grind teeth/clench Jaws/have TMJ pain? If so, please circle answer
- o Yes o No Gag easily
- o Yes o No Brush daily If so, how often?_____
- o Yes o No Floss daily?If so, how often?_____
- o Yes o No Require Antibiotics for dental work?
- o Yes o No Need dental work completed (referred from another dentist or you feel they do)
- o Yes o No Presently in dental pain?_____
- o Yes o No Have any extra, missing, or extracted teeth? If so, please circle answer_____
- o Yes o No Have a history/present today with trauma to the head, face, or teeth?_____
- o Yes o No Have any other habits not listed above? If yes, please specify_____
- o Yes o No Have seen ortho/endo/perio/oral surg? If yes, who_____

MEDICAL

Please check any that may apply to you/your child & circle exact answer

- O Immunizations up to date
- O Asthma/Respiratory problems O Epilepsy/Seizures O Mental Disorder
- O Autism/ADD/ADHD O Endocrine O Rheumatic Fever
- O Brain Injury O Gastrointestinal/Kidney O Speech Delay
- O Bleeding disorder/Delay/Anemia O Heart Murmur O Transfusion
- O Cancer O Hepatitis/Liver/Infectious Disease O Tuberculosis
- O Cerebral Palsy/CNS problem O Herpes/Fever Blisters O Vision Disorder
- O Congenital Heart Defect/Problem O Developmental Delay O Pregnant/Taking oral contraceptive
- O Tobacco/Smoke/Drug/Alcohol Abuse O Diabetes O Lung Problems
- O Other:_____

If you said yes to any of the above, please explain:_____

Current medications & dosages: _____

Allergies or adverse reactions to any medications (e.g. penicillin/sulfas):_____

Allergies to any substances (e.g. latex):_____

Previous hospitalizations, surgeries, or serious illnesses, and date: _____

Have you/your child had any abnormal bleeding associated with previous extractions, surgery, or trauma? If yes, please explain:_____

Date of last dental visit (if new patient):_____Previous dentist:_____

Pediatrician/Primary Care Physician:_____ Phone Number:_____

Is there anything else you would like us to be aware of regarding you/your child?_____

I understand that providing incorrect information can put my/my child's health at risk and that it is my responsibility to inform the dental office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services that my/my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my/my child during the period of such care to third party payers and/or other health practitioners as necessary. We may request release of my/your child's medical and dental records. With your permission, you agree to release your/ your child's records to another doctor at their/your request.

Signature of Parent/Guardian/Patient X_____ Date:_____