



Pediatric Patient Health History



Child's Name: _____

Date of Birth: _____

Parent/Guardian name: _____

Home Phone: _____

Address: _____

Cell Phone: _____

We prefer that you confirm appointments electronically. Please provide your email so we may send appointment reminders.

Email _____ @ _____

PEDIATRIC DENTAL HISTORY

Check (✓) all that apply for your child:

- head injury mouth injury tooth injury nail biting
- thumb sucking mouth breathing pain
- negative past experience with a dentist or doctor
- other (please explain) : _____

- Does your child brush daily? Yes No Is dental floss used? Yes No
- Do you assist with brushing? Yes No Are disclosing tablets used? Yes No

- How does your child receive fluoride? water supply tablets toothpaste vitamins dentist
- none other: _____

New Patients Only

Name of former dentist: _____ Date of last dental exam: _____

Address: _____ Date of last dental x-rays: _____

PEDIATRIC MEDICAL HISTORY

Pediatrician's Name: _____ Date of last visit: _____

Has your child been immunized? Yes No Have your child ever had any serious illnesses or operations? No Yes
(please explain below):

Check (☆) all that apply:

- alcohol abuse anemia hemophilia Other: _____
- bleeding disorder asthma herpes _____
- drug abuse coughing up blood kidney disease _____
- heart murmur diabetes liver disease _____
- hepatitis epilepsy / seizures scarlet or rheumatic fever _____
- HIV/AIDS fainting tobacco use _____
- tuberculosis GERD / reflux tonsillitis _____

ALLERGIES

- NONE
- aspirin local anesthetic penicillin
- codeine LATEX sulfa
- other: _____
- other: _____

MEDICATIONS

List **ALL** medications and supplements your child is taking.
Use other side if necessary.

I certify that the above information is complete and correct. I will not hold my dentist or any member of his staff responsible for any action they take or do not take because of errors or omissions I may have made on this form.

Patient signature: _____

Date: _____

STAFF USE ONLY

- LATEX ALLERGY see med list Hx taken by: _____ Dentrix updated