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 ☐ tonsilitis

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

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