KIDS TOWN PEDIATRIC DENTISTRY

Patient Health History

PATIENT NAME: _____ **DOB:** _____/_____/_____

DENTAL HISTORY:

Why is your child here today? ☐First Dental Visit ☐Checkup ☐Other_____

Has your child been to the Dentist before? ☐Yes ☐No If yes, date? _____

How was your child's experience (check one) ☐Excellent ☐Good ☐Fair ☐Poor?

Has your child had dental x-rays taken before? ☐Yes ☐No

Is your child currently taking fluoride? ☐Yes ☐No If yes, how often? _____ x daily

Does the patient have any of the following oral habits?
☐finger or thumb sucking ☐pacifier ☐nail biting ☐lip sucking ☐biting ☐grinding

Is the patient breast feeding or still on a bottle? ☐Yes ☐No Using sippy cup? ☐Yes ☐No

AT HOME DENTAL CARE:
How often does your child brush their teeth? _____ x daily. Who brushes? ☐Child ☐Parent
How often does your child floss their teeth? _____ x daily. Who flosses? ☐Child ☐Parent

MEDICAL HISTORY:

Name of Primary Physician? _____
Date of last Medical exam? _____Are your child's shots current? ☐Yes ☐No
Is your child currently under the care of a physician for any reason? ☐Yes ☐No
If yes, what for? _____
Has your child ever had a traumatic medical/dental related injury? ☐Yes ☐No
If yes, what? _____When?_____
Has your child ever been hospitalized? ☐Yes ☐No
If yes, what for? _____When? _____

Health History

Patient Name: _____ DOB: ____/____/____

Does the patient have or have they ever had any of the following?

	YES	NO
ADD/ADHD	☐	☐
AIDS/HIV Positive	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Autism/Spectrum disorder	☐	☐
Blood Disease	☐	☐
Specifically:_____		
Cancer	☐	☐
Chemotherapy	☐	☐
Cerebral Palsy	☐	☐
Cleft lip	☐	☐
Cleft Palate	☐	☐
Congenital Birth defect	☐	☐
Specifically:_____		
Congenital Heart Defect	☐	☐
Developmental delay	☐	☐
Diabetes	☐	☐
Down Syndrome	☐	☐
Endocrine Disorder	☐	☐
Epilepsy or Seizures	☐	☐
Excessive Bleeding	☐	☐
GI System Condition	☐	☐
Heart Condition	☐	☐
Specifically:_____		

	YES	NO
Heart Murmur	☐	☐
Heart Surgery	☐	☐
Hearing impaired	☐	☐
Hepatitis A, B or C	☐	☐
Kidney Problems	☐	☐
Leukemia	☐	☐
Liver Disease/Problem	☐	☐
Mental Disability / Disorder	☐	☐
Physical Disability	☐	☐
Premature Birth	☐	☐
Pregnancy	☐	☐
If yes, due date:_____		
Radiation Treatment	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐
Sinus Trouble	☐	☐
Stroke	☐	☐
Thyroid or other gland disorder	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Vision impaired	☐	☐
Venereal Disease	☐	☐
Other	☐	☐
Please list_____		

DOES YOUR CHILD HAVE ALLERGIES TO ANY OF THE FOLLOWING:

☐Local Anesthetic ☐Penicillin / Amoxicillin ☐Sulfa ☐Latex ☐Codeine ☐Other_____

Please list any medications your child is on and what they are taking it for:

_____

The information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature of parent or guardian Date