

# New Patient Medical History

Patient's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Patient's Gender:  Male  Female   
Name of parent/guardian: \_\_\_\_\_ Relationship to child/patient: \_\_\_\_\_  
Guardian/Parent's SSN: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Insurance Policy Holder's Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Enrollee ID/Policy Number and Group Number if applicable: \_\_\_\_\_  
Policyholder's date of birth: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

## Dental History

**Is this your child's first dental visit?**  Yes  No  
If yes, how does your child feel about their first visit?  Excited  Nervous  Anxious  
 Other: (please describe) \_\_\_\_\_  
If no, have they had any issues with dental treatment in the past?  Yes  No  
If yes, please explain: \_\_\_\_\_

### When was your child's last dental visit?

Were xrays taken at their last dental visit?  Yes  No  
Have any cavities been noted in the past?  Yes  No  
Was a cleaning completed at their last dental visit?  Yes  No

Previous dentist/dental office: \_\_\_\_\_

Previous dentist's phone number: \_\_\_\_\_

**Is your child undergoing orthodontic treatment (braces)?**  Yes  No

Orthodontist's name: \_\_\_\_\_

**Does your child eat/drink sweets or juice?**  Yes  No

How often? \_\_\_\_\_

**Does your child use a pacifier/suck on their thumb/fingers?**  Pacifier  Fingers/Thumb  Neither

**When does your child brush their teeth/you brush their teeth? (Please mark all that apply)**

Morning  Evening  After eating

**Has your child had any dental trauma or injuries?**  Yes  No

Explain: \_\_\_\_\_

**Any specific questions or concerns that you have for the doctor or hygienist?**

# Health History

Does your child currently have or have a history of any of the following illnesses? Check all that apply

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Epilepsy, Seizures, Fainting |
| <input type="checkbox"/> HIV/AIDS                      | <input type="checkbox"/> Vision Problems              |
| <input type="checkbox"/> Autism                        | <input type="checkbox"/> Exposure to secondhand smoke |
| <input type="checkbox"/> ADHD/ADD                      | <input type="checkbox"/> G-Tube                       |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Hearing Loss                 |
| <input type="checkbox"/> Congenital Defects            | <input type="checkbox"/> Heart Disorders              |
| <input type="checkbox"/> Cerebral Palsy                | <input type="checkbox"/> Herpes/Cold Sores            |
| <input type="checkbox"/> Developmental Delay           | <input type="checkbox"/> Infections                   |
| <input type="checkbox"/> Down Syndrome                 | <input type="checkbox"/> Sensory Disorder             |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Sleep apnea                  |
| <input type="checkbox"/> Emotional/Mental Disabilities | <input type="checkbox"/> Lung disorder                |

Does your child have any other medical conditions or health problems not listed above?

Yes  No

If yes, please explain:

Has your child ever undergone surgery/surgical procedures?

Yes  No

If yes, please list the type of surgery and dates completed:

Name of pediatrician/family doctor and any specialists your child sees:

Phone number(s)

What is the vaccination status of your child?

Up to date  Not up to date

Unable to vaccinate due to medical reasons

Not vaccinated due to personal/religious reasons

List all medications and vitamins/supplements your child takes:

Is your child allergic to any of the following things?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Amoxicillin/Penicillin | <input type="checkbox"/> Sulfa/Bactrim     | <input type="checkbox"/> Artificial Colors/Dyes |
| <input type="checkbox"/> Tylenol/Acetaminophen | <input type="checkbox"/> Clindamycin            | <input type="checkbox"/> Latex             |   |
| <input type="checkbox"/> Ibuprofen             | <input type="checkbox"/> Codeine                | <input type="checkbox"/> Metal Sensitivity |   |

Name & Number/Location of Preferred Pharmacy:

Date:

Guardian  
Signature

Guardian's Name: