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

- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Autism
- ☐ ADHD/ADD
- ☐ Cancer
- ☐ Congenital Defects
- ☐ Cerebral Palsy
- ☐ Developmental Delay
- ☐ Down Syndrome
- ☐ Diabetes
- ☐ Emotional/Mental Disabilities
- ☐ Epilepsy, Seizures, Fainting
- ☐ Vision Problems
- ☐ Exposure to secondhand smoke
- ☐ G-Tube
- ☐ Hearing Loss
- ☐ Heart Disorders
- ☐ Herpes/Cold Sores
- ☐ Infections
- ☐ Sensory Disorder
- ☐ Sleep apnea
- ☐ 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?

- ☐ Aspirin
- ☐ Tylenol/Acetaminophen
- ☐ Ibuprofen
- ☐ Amoxicillin/Penicillin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Sulfa/Bactrim
- ☐ Latex
- ☐ Metal Sensitivity
- ☐ Artificial Colors/Dyes

Name & Number/Location of Preferred Pharmacy:

Date:

Guardian Signature _____

Guardian's Name: