Staff: _____

Today's Date: _____

# Patient Medical/Dental History

Child's Name: _____ Preferred name: _____

Date of Birth: _____ ❑ Male ❑ Female Lives with: ❑ Mother ❑ Father ❑ Legal Guardian ❑ Foster Parents

Name of person completing this form: _____ Relationship to Patient: _____

Child's Physician: _____ Physician's Phone: (_____) _____

Preferred Pharmacy _____

Is this your child's first visit to the dentist? ❑ Yes or ❑ No If no who was the Previous Dentist/City? _____

**Medical History:** Has/Is your child:

A) Receiving any medication or drugs? _____

B) Under care for on-going condition(s)? _____

C) Ever been hospitalized/major surgery? _____

D) Allergies: Food / Drug / Latex / Seasonal Please Explain: _____

E) Immunizations current? ❑ Yes or ❑ No

**Any history or difficulty with any of the following? (check all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| ❑ Asthma | ❑ Bleeding Disorders | ❑ Chronic Sinus | ❑ Hepatitis/Liver | ❑ Hearing | ❑ Kidney |
| ❑ Rheumatic Fever | ❑ Reflux | ❑ Autism Spectrum | ❑ Cerebral Palsy | ❑ Convulsions | ❑ HIV/AIDS |
| ❑ Developmental Delay | ❑ Epilepsy | ❑ Anemia | ❑ Physical Disabilities | ❑ Cancer/Tumor | ❑ Diabetes |
| ❑ Heart (Pre-Med Y/N?) | ❑ Fainting | ❑ Other: _____ | | | |

**Dental History:** Has/Is your child:

A) Mentioned any dental problems? ❑ Yes or ❑ No _____

B) Had any unfavorable dental experiences? ❑ Yes or ❑ No _____

C) Had any mouth / teeth / head injuries? ❑ Yes or ❑ No _____

**Does your child have any of the following habits? (check all that apply)**

| | | | | |
|---|---|---|---|---|
| ❑ Bottle at Bedtime | ❑ Nursing at Bedtime | ❑ Pacifier or Thumb Sucking | ❑ Finger or Lip Sucking | ❑ Teeth Grinding |
| ❑ Mouth Breathing | ❑ Tongue Thrust | ❑ Tobacco use | ❑ Jaw Problems | ❑ Speech Issues |

*AUTHORIZATION: I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Puget Sound Pediatric Dentistry consent to do an oral exam, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions, as deemed appropriate. I understand I will be consulted before any another treatment is rendered. I understand that this information will be used by our dentists to help determine the appropriate and ideal dental treatment. If there is any change in my child's medical status, I will inform the office immediately.*

_____ / _____ _____

Signature Print Name Date