Medical and Dental History

Patient's Name_____ Birthdate_____ Age_____ □ Male □ Female

MEDICAL HISTORY

Physician_____

Yes No
( ) ( ) Is patient in good health?
( ) ( ) Is patient under a physicians care? For what?_____
( ) ( ) Does patient have any history of major illness? What?_____
( ) ( ) Has patient ever been hospitalized? For what?_____
( ) ( ) Is the patient receiving any medication/drugs presently?_____
( ) ( ) Does patient have any allergies or drug sensitivity? Kindly List_____
( ) ( ) Does patient have a tendency to colds( ), sore throat( ), ear infections( ), sinus congestion( ), breathing problems( )
( ) ( ) Have tonsils and/or adenoids been removed? What age?_____

Various medical conditions affect how we provide dental care for your child. Please check any of the following conditions for which the patient has been diagnosed:

( ) Arthritis
( ) Asthma
( ) Autism
( ) Blood Disorders
( ) Cerebral Palsy
( ) Developmental Delays
( ) Diabetes
( ) Epilepsy/Seizures
( ) Emotional Problems
( ) Endocrine Problems
( ) Fainting/Dizziness
( ) Heart Problems
( ) HIV Positive
( ) Liver/Kidney Disease
( ) Nutritional Problems
( ) Prolonged Bleeding
( ) Rheumatic Fever
( ) Speech, Hearing Problem
( ) Tuberculosis

Any other significant medical, psychological, or disability problems? ___ Please describe. _____
_____

DENTAL HISTORY

Previous Dentist_____

Yes No
( ) ( ) Has there been any injuries to the face, mouth or teeth?_____
( ) ( ) Has the patient ever sucked their thumb or fingers? Until what age? _____
( ) ( ) Does the patient have any speech problems? _____
( ) ( ) Is the patient a mouth breather? While awake? _____
( ) ( ) Does the patient have noticeable problems in chewing or swallowing? _____
( ) ( ) Any clicking, popping, or discomfort upon opening or closing their mouth? _____
( ) ( ) Does the patient see a dentist regularly? Date last seen? _____
( ) ( ) Has any previous dental treatment occurred? If yes, what? _____
( ) ( ) Were there any problems with the previous dental treatment? If yes, what were they? _____
( ) ( ) Is your drinking water fluoridated?
( ) ( ) Are supplemental fluorides (e.g. rinse, gel, tabs) used? Please describe _____
How often are teeth brushed? _____ Flossed? _____ By whom?_____
If there are any special concerns, please state in your own words._____

I acknowledge that this information is correct and hereby authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services. I authorize the use of any anonymous radiographs, photographs, and records for the purpose of teaching other health care professionals.

_____ _____ _____ _____
Signature of Legal Consent Date Dentist Signature Date

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