pediatric dental group

Child's Name _____ Birthday _____
Please Print (Last) (First) (MI)

Is English your primary language? ❑ Yes ❑ No

Medical History

Child's Physician _____ Address _____ Phone # ( ) _____

Date of Last Visit _____ Reason _____

Is your child in good physical health? ❑ Yes ❑ No
Is your child up to date with immunizations? ❑ Yes ❑ No
Is there any possibility your child could be pregnant? ❑ Yes ❑ No
Has your child been hospitalized since his/her birth? ❑ Yes ❑ No
Does your child have any physical/mental/muscular/handicaps? ❑ Yes ❑ No
State law requires we ask.

Please check any of the following that may pertain to your child:
Does your child need to be pre-medicated due to a medical condition? ❑ Yes ❑ No

❑ Heart Murmur	❑ Epilepsy	❑ Latex Allergy	❑ Seizures	❑ Brain Injury
❑ Heart Condition	❑ Diabetes	❑ Cancer	❑ Learning Disability	❑ Anemia
❑ Lung Problem	❑ Cerebral Palsy	❑ Tuberculosis	❑ Handicaps	❑ Rheumatic Fever
❑ Bleeding Problem	❑ Sickle Cell Anemia	❑ Asthma	❑ Hearing Problems	❑ RSV
❑ Liver Problem	❑ Hepatitis	❑ Allergies (seasonal)	❑ Sight Problems	❑ Allergy to tree sap or resin
❑ Kidney Problem	❑ AIDS / HIV+	❑ Sinus Problems	❑ Blood Transfusions	❑ Other _____

Please describe any Medical Condition that was checked above: _____

_____

Please list all Medications your child is taking _____

Is your child allergic to any Medications? ❑ Yes ❑ No If yes, list _____

Is there any possibility your child could be pregnant? ❑ Yes ❑ No State law requires that we ask.

Dental History

Reason Your Child is Here Today _____
Is your child in any dental discomfort today? ❑ Yes ❑ No

Is this your child's first dental visit? ❑ Yes ❑ No Date of last visit _____ Were X-Rays taken? _____
Has your child had an unfavorable experience in a dental office? ❑ Yes ❑ No

If yes, please explain _____
Has your child experienced any unfavorable reactions to a local anesthetic or laughing gas? ❑ Yes ❑ No

Child's Previous Dentist _____ Address _____ Phone # ( ) _____
What is your water source? ❑ Private Well ❑ Public System

Does your child suck their thumb or finger? ❑ Yes ❑ No
Does your child use a pacifier? ❑ Yes ❑ No
Was your child bottle fed? If yes, age it was discontinued? ❑ Yes ❑ No
Has your child ever had trauma to their teeth? ❑ Yes ❑ No
Does your child have any history of speech problems? ❑ Yes ❑ No
Have you or any of your children had orthodontic treatment? ❑ Yes ❑ No

How do you assist your child with tooth brushing? _____

Permission

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes to my child's medical status. A copy of Pediatric Dental Group's Notice of Privacy Practices is available upon request.

Parent / Guardian's Signature _____ **Date** _____