Davis Pediatric Dentistry

Pediatric Medical History Form

PATIENT NAME: _____ PHONE: _____

ADDRESS: _____

DATE OF BIRTH: _____ AGE: ____yrs ___mos HEIGHT: _____ WEIGHT: _____ GENDER:_____

CHILD'S DENTAL HISTORY:

YES NO

□ □ IS THIS YOUR PATIENT'S FIRST DENTAL VISIT? IF NO, HOW LONG SINCE LAST DENTAL EXAMINATION? _____

□ □ IS THIS AN EMERGENCY VISIT? IF YES, PLEASE EXPLAIN_____

□ □ HAVE ANY TEETH BEEN REMOVED BY A DENTIST?

□ □ DOES THIS PATIENT HAVE A PROBLEM WITH THEIR BITE OR POSITION OF TEETH?

□ □ HAS THIS PATIENT BEEN SEEN BY AN ORTHODONTIST?

□ □ HOW MANY TIMES A DAY DOES THIS PATIENT BRUSH THEIR TEETH? _____

□ □ IS DENTAL FLOSS USED?

□ □ DOES THIS PATIENT HAVE A HISTORY OF: (PLEASE CIRCLE) FINGER OR THUMB SUCKING, LIP SUCKING, NAIL BITING, USE OF A PACIFIER, GRINDING/CLENCHING TEETH, SLEEP APNEA/ SNORING

□ □ HAVE THERE BEEN ANY INJURIES TO THE TEETH

□ □ DOES THIS PATIENT HAVE ANY OF THE FOLLOWING JAW PROBLEMS: (PLEASE CIRCLE) CLICKING OF JAW, DIFFICULTY OPENING OR CLOSING JAW, DIFFICULTY CHEWING, STIFF JAW ON AWAKENING, JAW STUCK OPEN OR CLOSED, CLENCHING OR GRINDING OF TEETH, OR FREQUENT HEADACHES

CHILD'S MEDICAL HISTORY

MEDICATIONS: Medication and Dosage

_____

Does your child require antibiotic prophylaxis prior to dental treatment? □ No □ Yes

ALLERGIES: □ No □ Yes If yes, to what?

_____

IMMUNIZATION HISTORY: To the best of my knowledge, my child is up to date on his/her immunizations
□ No □ Yes IF NO EXPLAIN WHY? _____

MEDICAL HISTORY: Please check if your child has had any of the following medical problems:

□ Cardiac Condition □ ADD/ADHD □ Autism Spectrum Disorder □ Headaches □ Liver Disease/Hepatitis
□ Concussion □ Hearing Problems □ Anemia □ Diabetes □ Chronic Adenoid/ Tonsil Infections □ Seizures
□ Asthma □ Bleeding Disorder □ High Blood Pressure □ Kidney Disease □ Vision Problems □ Cancer

Any special needs or significant medical history not mentioned above?

_____

HOSPITALIZATIONS: Has your child every stayed overnight in a hospital? □ No □ Yes
If yes, why?

_____

SURGICAL HISTORY: Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

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RESPONSIBLE PARTY INFORMATION

Name_____ Relationship to Patient_____

Address_____

Marital Status:_____ Home Phone_____ Work Phone _____

Email _____ Cell Phone _____

Previous Address (if less than 3 years)

_____

Social Security # _____ Birth Date_____Relationship to Patient_____

Occupation_____Employer _____ # of Years at Present Job_____

*** I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY FOR ANY SERVICES RENDERED FOR THE PATIENT NAMED ABOVE ARE MINE. IN THE EVENT THERE IS DENTAL INSURANCE COVERAGE, DAVIS PEDIATRIC DENTISTRY WILL ASSIST IN PROCESSING MY INSURANCE CLAIM. ***

*** I UNDERSTAND THAT, AT THE TIME SERVICES ARE RENDERED, PAYMENT MAY BE DUE IN FULL AND THAT A FINANCE CHARGE MAY BE ASSESSED ON BALANCES CARRIED OVER 60 DAYS *** *** THE OFFICE RESERVES THE RIGHT TO CONDUCT A CREDIT CHECK ***

*** I understand I am financially responsible whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such action be required. ***

I agree that a photocopy of this authorization shall be valid as the original.

SIGNATURE OF RESPONSIBLE PARTY NAMED ABOVE: _____

DO YOU HAVE DENTAL INSURANCE? Yes____No___

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ARE ANY OTHER FAMILY MEMBERS SEEN HERE? IF YES, PLEASE LIST THEIR NAMES:

_____

Child's Father_____ Marital Status _____

□ ADDRES SAME AS ABOVE

Address _____

Phone _____ Birth Date _____ Employer_____

Child's Mother _____ Marital Status _____

□ ADDRES SAME AS ABOVE

Address _____

Phone _____ Birth Date _____ Employer_____

I AUTHORIZE ROUTINE DENTAL DIAGNOSTIC PROCEDURES FOR MY CHILD.

SIGNATURE OF PARENT OR LEGAL GUARDIAN

_____DATE _____ _____

IN THE EVENT OF A PROPOSED TREATMENT PLAN, I ALSO AGREE TO THE USE OF ANESTHETICS, ANALGESICS, AND PREMEDICATIONS CONSIDERED NECESSARY OR ADVISABLE BY THE DENTIST FOR THE COMFORT AND WELL-BEING OF THE CHILD.

SIGNATURE OF PARENT OR LEGAL GUARDIAN

_____DATE _____