Patient Health Information

Patient's Name_____ Date_____

Is your child currently under the care of a physician? Yes ☐ No ☐

If yes, Why?_____

Child's Physician: _____

Phone #:_____ Last Visit: _____

Has your child ever had general anesthesia or sedation? Yes ☐ No ☐

If yes, when:_____

Were there any complications: _____

Please describe the child's health: Good Fair Poor

Is your child allergic to anything? Yes ☐ No ☐

IF YES, WHAT:_____

_____

Please list all drugs the child is currently taking: _____

_____

_____

Comments:

Does your child require antibiotics prior to invasive dental procedures? YES NO

If yes, please explain:_____

Has the child been diagnosed or treated for any of the following conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Hearing Loss	☐	☐	Sickle Cell Anemia
☐	☐	Arthritis	☐	☐	Heart Disease	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Snoring at Night
☐	☐	Autism	☐	☐	Hemophilia	☐	☐	Sore Throat – Frequent
☐	☐	Bronchitis	☐	☐	Hepatitis – Type_____	☐	☐	Spina Bifida
☐	☐	Cancer	☐	☐	Immunodeficiency	☐	☐	Syndrome
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	IF YES, WHAT:_____
☐	☐	Cleft Lip / Palate	☐	☐	Measles / Mumps			_____
☐	☐	Convulsions / Seizures	☐	☐	Mouth Breathing	☐	☐	Tetanus
☐	☐	Developmentally Delayed	☐	☐	Nutritional Deficiency	☐	☐	Tonsils / Adenoids
☐	☐	Diabetes	☐	☐	Orthopedic Problems	☐	☐	Tuberculosis
☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐	Whooping Cough
☐	☐	Eye Problems	☐	☐	Polio	☐	☐	Other_____
☐	☐	Excessive Bleeding	☐	☐	Psychiatric Disorder			_____
☐	☐	Fainting	☐	☐	Rheumatic / Scarlet Fever			_____
☐	☐	Gastrointestinal (stomach)	☐	☐	Scoliosis			_____

Is there anything else you think we should know about your child?_____

Has your child been seen by a dentist before? Y N Date last seen_____ Name of Dentist _____

Has your child ever had a serious/difficult problem associated with dental work? Y N

Please explain:_____

_____

At what age did your child stop bottle/breast feeding? _____ Is the child's water fluoridated? Y N Unknown

Is the child taking any fluoride supplements? Y N Does the child suck his/her thumb or fingers or pacifier? Y N

Would you like to speak to the Doctor privately about any problem? Y N

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of person completing this form: _____ Date:_____

Relationship to patient:_____

Dentist's Signature: _____ Date:_____