## 6 Why did you bring the child to the dentist today? _____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

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

Please describe the child's current physical health:
☐ Good ☐ Fair ☐ Poor

Has your child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that the child is allergic to: _____

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

## 7 Has the child ever had any of the following medical problems?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Convulsions / Epilepsy |
| Y | N | ADD/ADHD | Y | N | Diabetes |
| Y | N | Allergies to any drugs | Y | N | Handicaps / Disabilities |
| Y | N | Any Hospital Stays | Y | N | Hearing Impairment |
| Y | N | Any Operations | Y | N | Heart Murmur |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Hemophilia |
| | | | Y | N | Hepatitis |
| Y | N | Asperger Syndrome | Y | N | HIV+ / AIDS |
| Y | N | Asthma | Y | N | Kidney / Liver Problems |
| Y | N | Autism | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Cancer | Y | N | Sickle Cell Disease / Traits |
| Y | N | Congenital Heart Defect | Y | N | Tuberculosis (TB) |

Please discuss any serious medical problems that the child has had:

## 8 Does/did the child have any of the following habits?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Lip Sucking / Biting | Y | N | Nursing Bottle Habits |
| Y | N | Nail Biting | Y | N | Thumb / Finger Sucking |

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Neighbor or Relative not living with you.

Name: _____ Phone: (____) _____

Address: _____

CITY STATE ZIP

## 9

I understand that the information that 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 in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

**Medical History Update**

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____


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