

PEDIATRIC DENTISTRY MEDICAL & DENTAL HISTORY

Patient's Last Name	Patient's First Name	Middle Initial	Nickname
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Gender Identity: She/Her He/Him They/Them	Birthdate	Home Phone Number
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Home Address: Street	City	State	Zip Code
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Legal Guardian #1 Name	Birthdate	Social Security #	Cell Phone Number
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Legal Guardian #1 Occupation/Employer	Email Address	Relationship to Patient
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Legal Guardian #2 Name	Birthdate	Social Security #	Cell Phone Number
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Legal Guardian #2 Occupation/Employer	Email Address	Relationship to Patient
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Marital Status: Single Separated Married Divorced Widowed Other

Name and Ages of Siblings	Previous Dentist	Pediatrician
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Do you want to give us permission to speak to anyone else about your family's treatment or bill? Yes No

If yes, please specify who: _____

How did you hear about us? Referral Social Media/Internet Community Event Family/Friends Pediatrician PDA Employee

Whom may we thank for referring you? _____

MEDICAL HISTORY

1) History:

- Were there any difficulties during pregnancy, delivery or first year of life?..... Yes No
 If yes, please explain: _____
- Was your child premature?..... Yes No
- Was your child adopted?..... Yes No
 If yes, are you the legal guardian? _____
 If yes, does your child know? _____
- Is a physician treating your child now for any specific illnesses?..... Yes No
 If yes, please explain: _____
- Are your child's immunizations up to date?..... Yes No
- Have antibiotics ever been recommended for your child before a dental visit?..... Yes No
 If yes, please explain: _____
- Does your child frequently get cold sores?..... Yes No

2) Hospitalizations:

- Has your child ever been hospitalized, had an operation or has an upcoming operation?..... Yes No
 If yes, please explain: _____
- Was general anesthesia used?..... Yes No
 If yes, any complications (ie. Malignant hyperthermia)? _____

Patient's Last Name _____ Patient's First Name _____ Birthdate _____

3) Medications:

Is your child taking any medication at this time? Yes No
 If yes, please list below.

MEDICATION NAME	HOW MUCH?	HOW OFTEN?	REASON?

Has your child taken any medications in the past? Yes No
 If yes, please explain: _____

4) Allergies: Does your child have any allergies or unusual reactions to any of the following?

- Latex Yes No If yes, please explain: _____
- Medications Yes No If yes, please explain: _____
- Food Yes No If yes, please explain: _____
- Other Yes No If yes, please explain: _____

5) Development & Special Needs:

- Does your child have difficulty talking and understanding at their age level? Yes No
- Does your child attend a special class, school or services? Yes No
- Does your child use a wheelchair/walker for transportation? Yes No
 If yes, please specify: _____

6) Medical Conditions: Does your child have any history of the following? (Please check all that apply)

If your child does not have any medical conditions, please check here: None

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| <ul style="list-style-type: none"> <input type="checkbox"/> Cardiac Disorders (Heart Related) <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Previous Bacterial Endocarditis <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Lung/Airway Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Adenoid/Tonsil Problems <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Endocrine Disorders (Hormone Related) <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyper/Hypothyroidism <input type="checkbox"/> History of Steroids <input type="checkbox"/> Gastrointestinal Disorders (Stomach Related) <input type="checkbox"/> Acid Reflux / GERD <input type="checkbox"/> Nutritional Deficiency <input type="checkbox"/> Inflammatory Bowel Disease (ie. Crohns) <input type="checkbox"/> Musculoskeletal Concerns <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Substance Use <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug: _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Kidney or Bladder Problems <input type="checkbox"/> Liver Disease <input type="checkbox"/> Hematologic Concerns (Blood Related) <input type="checkbox"/> Hemophilia <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Transfusion of Blood <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Diseases (ie. Herpes, HPV):
List: _____ <input type="checkbox"/> Behavior & Learning Concerns <input type="checkbox"/> ADHD (ADD) <input type="checkbox"/> Behavior Issues:
List: _____ <input type="checkbox"/> Eating Disorder:
List: _____ <input type="checkbox"/> Emotional/Psychiatric Disorder:
List: _____ <input type="checkbox"/> Learning Disability:
List: _____ <input type="checkbox"/> Speech Delay/Problems <input type="checkbox"/> History of Abuse (physical/psychological) | <ul style="list-style-type: none"> <input type="checkbox"/> Growth & Developmental Disorders <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Anxiety/Nervousness <input type="checkbox"/> Brain Injury/Cerebral Palsy <input type="checkbox"/> Congenital Birth Defects <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Depression <input type="checkbox"/> Developmental Delay (Physical/Mental) <input type="checkbox"/> Fainting/Dizziness/Frequent Headaches <input type="checkbox"/> Feeding/Eating Problems <input type="checkbox"/> Hearing Problems:
List: _____ <input type="checkbox"/> Neuromuscular Defect <input type="checkbox"/> Seizure History/Epilepsy <input type="checkbox"/> Vision Problems <input type="checkbox"/> Miscellaneous <input type="checkbox"/> Cancer/Malignancies:
List: _____ <input type="checkbox"/> Syndrome:
List: _____ <input type="checkbox"/> Additional Comments: _____

 _____ |
|--|---|---|

Patient's Last Name _____

Patient's First Name _____

Birthdate _____

DENTAL HISTORY

- 1) Why is your child here today? _____

- 2) Dental History:
 - Has your child been to a dentist previously? _____ Yes No
 If yes, when was the last visit? _____
 - Have x-rays been taken? _____ Yes No
 If yes, when and what type of x-rays? _____
 - Has your child had local anesthetic (Novocaine)? _____ Yes No
 If yes, were there any problems? _____
 - Does a Parent/Sibling/Primary Caregiver have a history of cavities? _____ Yes No
 - Did your child have a difficult/traumatic experience their previous provider? _____ Yes No
 - How would you describe your child's dental experience?
 Outgoing Cooperative Stubborn Anxious Shy Frightened Curious Friendly Defiant
 - How do you think your child will react to dental treatment? _____

- 3) Fluoride: Has your child had fluoride in any of the following forms?
 - Fluoride tablets/supplements _____ Yes No If yes, please circle: 0.25mg 0.5mg 1.0mg
 - Toothpaste _____ Yes No If yes, please list brand: _____
 - Fluoride rinse/gel _____ Yes No If yes, please list brand: _____
 - Drinking water (community water fluoridation) _____ Yes No
 - In-Office fluoride varnish/treatment at dentist/pediatrician _____ Yes No If yes, date of last application: _____

- 4) Brushing:
 - Does your child brush their own teeth? _____ Yes No
 - When do they brush? _____ AM PM
 - Do you help brush your child's teeth? _____ Yes No
 - Does your child use dental floss in cleaning their teeth? _____ Yes No

- 5) Diet:
 - Does your child have greater than 3 sugary snacks or beverages between meals? _____ Yes No
 If yes, what do those snacks usually consist of? _____
 - How much soda/juice/energy drinks does your child usually drink per day? _____

- 6) Trauma: Have your child's teeth ever been injured? _____ Yes No
 If yes, age when injured? _____ Which teeth? _____ Cause of injury? _____
 Did your child receive treatment? _____ Yes No
 If yes, describe the treatment? _____

- 7) Habits: Does your child have any of the following habits? Check all that apply.
 Bottle to bed/nap time Breastfeeding Thumb/Finger sucking Pacifier Mouth breathing Grinding of teeth
 Excessive gagging Other _____

- 8) Has your child received any unusual dental or surgical treatments to the mouth? _____ Yes No
 If yes, please specify: _____

- 9) Is there anything else you would like to tell us about your child's dental history? _____ Yes No
 If yes, please specify: _____

I certify that I have read and understand this information to the best of my knowledge. The questions have been accurately answered. It is my responsibility to inform the office of any changes in medical status. I hereby give permission to PDA Dental Group to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, cleanings, exams, topical and local anesthetics (injections), fillings, radiographs, etc.

Responsible Party's Signature _____

Date _____