Medical History

Name _____

History

		Yes	No
1.	Is your child being treated by a physician at this time?	❑	❑
2.	Has your child ever been a patient in a hospital?	❑	❑
3.	Has your child ever received general anesthesia?	❑	❑
4.	Is your child allergic to anything?	❑	❑
	If yes, what?_____		
5.	Is your child taking any medications at this time?	❑	❑
	If yes, what?_____		
6.	Has your child ever been seen by a dentist before?	❑	❑
7.	Has your child ever received fluoride in any form	❑	❑
	If yes, what?_____		
8.	Does your child suck his/her thumb or fingers? (Circle if appropriate)	❑	❑
9.	How many time per day are your child's teeth brushed? _____times		
10.	At what age did your child stop bottle/breast feeding? _____		

Illness

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS	❑	❑	Emotional Disturbances	❑	❑	Nutritional Deficiency
❑	❑	Anemia	❑	❑	Epilepsy	❑	❑	Orthopedic Problems
❑	❑	Allergy	❑	❑	Eye Problems	❑	❑	Pneumonia
❑	❑	Arthritis	❑	❑	Excessive Bleeding	❑	❑	Polio
❑	❑	Asthma	❑	❑	Fainting	❑	❑	Rheumatic Fever
❑	❑	Autism	❑	❑	Hearing Loss	❑	❑	Scarlet Fever
❑	❑	Brain Injury	❑	❑	Heart Disease	❑	❑	Scoliosis
❑	❑	Cancer	❑	❑	Hemophilia	❑	❑	Sicle Cell Anemia
❑	❑	Cerebral Palsy	❑	❑	Hepatitis Type ____	❑	❑	Spina Bifida
❑	❑	Chicken Pox	❑	❑	Jaundice	❑	❑	Syndrome _____
❑	❑	Cleft Lip/Palate	❑	❑	Leukemia	❑	❑	Tetanus
❑	❑	Convulsions/Seizures	❑	❑	Measles	❑	❑	Whooping Cough
❑	❑	Diabetes	❑	❑	Mental Retardation	❑	❑	Other _____
❑	❑	Diptheria	❑	❑	Mumps			_____

* Please complete the information on the other side of this form

Organs and Systems

Has your child ever had any treatment for any of the following? Please check yes or no:

Yes	No		Yes	No		Yes	No	
❑	❑	Blood - Circulatory	❑	❑	Gastrointestinal (stomach)	❑	❑	Muscles
❑	❑	Bones	❑	❑	Kidney - Bladder	❑	❑	Nervous System
❑	❑	Endocrine Glands	❑	❑	Heart	❑	❑	Skin
❑	❑	Eyes, Ears, Nose, Throat	❑	❑	Liver	❑	❑	Tonsils/Adenoids

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

_____

_____

_____

_____

_____ _____ _____

Signature of person completing form | Relationship to patient | Date

Patient Information

Date_____

Child's Name_____Nickname_____

Age_____ Date of Birth_____-_____-_____ Grade in school_____

Father's Name_____

Home Phone_____Cell Phone_____Work Phone_____

Social Security # _____-_____-_____ Date of Birth _____-_____-_____

Street Address_____ City_____Zip_____

e-mail _____

Employer _____ Department_____

Address _____

Mother's Name_____

Home Phone_____Cell Phone_____Work Phone_____

Social Security # _____-_____-_____ Date of Birth _____-_____-_____

Street Address_____ City_____Zip_____

e-mail _____

Employer _____ Department_____

Address _____

Name of person(s) responsible for this account_____

Name of Insurance Company_____Group #_____

Insurance Company Address_____

Insurance Company Phone # _____

Name of Parent Insured_____

Reason For Today's Visit_____

Whom May We Thank For Referring Your Child?_____

Physician _____ Phone_____

Pharmacy_____ Phone_____