Patient Name: Date of Birth:

Patient Medical History

Physician's Name: Physician's Phone Number:
Date of Last Physical: Reason:
Are your child's immunization's up to date? Yes No

Yes No Has your child ever been hospitalized? If yes, please describe when and why:

Yes No Has your child ever been treated in the emergency room? If yes, please describe when and why:

Yes No Has your child ever had surgery? If yes, please describe when and why:

Yes No Has your child ever had pre-medication with antibiotics before dental appointments?

List all current medications the patient is taking(prescription and over the counter), including the reason for taking the medication:

Please list any known allergies:

Has your child ever been diagnosed with or treated for the following?

Y N ADHD/hyperactivity
Y N Allergies
Y N Anemia
Y N Arthritis
Y N Asthma
Y N Autism
Y N Birth Defects
Y N Bladder Disease
Y N Bleeding Problems
Y N Breathing Problems

Y N Cancer/Tumor/Malignancy
Y N Cerebral Palsy
Y N Chemotherapy/Radiation
Y N Cleft lip/palate
Y N Developmental Delay
Y N Down Syndrome
Y N Diabetes
Y N GI/Stomach disease
Y N Hearing Impairment
Y N Heart Condition/disease

Y N Heart Murmur
Y N Hepatitis
Y N HIV/ AIDS
Y N Kidney Disease
Y N Latex Sensitivity/allergy
Y N Liver Disease
Y N Mental/Nervous Disorder
Y N Pregnancy
Y N Premature Birth

Y N Rheumatic Fever
Y N Seizures/ Epilepsy
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Tonsillectomy
Y N Transplant
Y N Tuberculosis
Y N Venereal Disease
Y N Vision Problems
Y N Other

If other, please specify:
Please provide more information on any of the above marked "yes":

Patient Dental History

When was your child's last dental visit?
Previous dentist's name and address:
Why did your child leave his/her previous dentist?
What is your main concern about your child's teeth?

Y N Do you supervise or assist your child in brushing his/her teeth?
Y N Does your child use dental floss?
Y N Does your child have a click, pop or other noise in the jaw joint?
Y N Does your child have any concerns about the appearance of his/her teeth?Describe:
Y N Does your child have a current or previous pacifier or thumb/finger sucking habit? Until what age?
Y N Has your child ever had an accident or injury involving the teeth/jaws? When and where?

Y N Was your child bottle fed? Until what age?
Y N Was your child breast fed? Until what age?

Please check below if your child has had problems or concerns with any of the following:

___ Cavities ___ Gum Infection ___ Grinding/Bruxism ___ Tooth Sensitivity ___ Crooked teeth
___ Toothache ___ Canker Sores ___ Jaw Pain ___ Tooth Color ___ Missing Teeth

Fluoride History

Your child drinks water primarily from: Public Supply:Company? Well Bottled: Brand?

Y N Does your child use toothpaste with fluoride?
Y N Does your child use fluoride rinses ?
Y N Do you have a reverse osmosis water filter? Prescribed by:
Y N Does your child take prescription fluoride tablets/drops? Type and dosage?

The information provided in this form is complete to the best of my knowledge. I will notify Healthy Young Smiles at future visits if any of the information changes. Person completing this form (print)/relationship to patient:

Signature: Date: