Pediatric Dental History

PATIENT NAME	NICKNAME	MALE	FEMALE	BIRTHDATE	TODAY'S DATE

Do both parents live with the patient? YES / NO If no, who has legal custody? _____

Names of all brothers and sisters and their ages: _____

Is this your child's first dental visit? YES / NO If no, who was your child's previous dentist? _____

Is your child presently having any specific problems? YES / NO

Describe _____

Last Dental Visit	Purpose	Last Complete Dental Exam

How often does your child brush? _____ Who brushes their teeth? _____ Is floss used? YES / NO

Does your child receive: Fluoride vitamins? YES / NO Fluoridated water? YES / NO

Please check any of the following that apply to your child:

- ❑ Tooth injury
- ❑ Jaw injury or discomfort
- ❑ Finger / thumb / lip sucking
- ❑ Nail biting
- ❑ Pacifier use (how long? _____)
- ❑ Bottle use (how long? _____)
- ❑ Breast feeding (how long? _____)
- ❑ Sippy cup (how long? _____)

Has your child had an unfavorable reaction to medical or dental care? YES / NO

If yes, please explain: _____

Pediatric Medical History

Child's Physician	City	Date child last saw physician

Is your child being treated by a physician at this time? YES / NO Why? _____

Is your child currently taking any medication? YES / NO What? _____

Has your child ever been hospitalized or had surgery? YES / NO For What? _____

Is your child allergic to any food or medicine? YES / NO What? _____

Was your child premature? YES / NO How much? _____

Is your child up to date on all immunizations? YES / NO

Please check Yes or No if any of the following apply to your child:

Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Diabetes or Endocrine Conditions	❑	❑	Pneumonia
❑	❑	Allergies	❑	❑	Drug Sensitivities	❑	❑	Pregnancy
❑	❑	Apnea	❑	❑	Headaches	❑	❑	Psychiatric Disorders
❑	❑	Arthritis	❑	❑	Hearing Loss	❑	❑	Rheumatic Fever
❑	❑	Asthma	❑	❑	Heart Murmur/Disease Type_____	❑	❑	Seizures
❑	❑	Autism or Asperger's	❑	❑	Hemophilia; Type_____	❑	❑	Sinus Problems
❑	❑	Attention Deficit Disorder	❑	❑	Hepatitis; Type _____	❑	❑	Special needs/disability
❑	❑	Birth Control	❑	❑	HIV	❑	❑	Syndromes _____
❑	❑	Bleeding Problems or Transfusions	❑	❑	Kidney or Liver Problems	❑	❑	Tuberculosis
❑	❑	Breathing or Lung Problems	❑	❑	Latex Allergy	❑	❑	Venereal Disease
❑	❑	Cancer	❑	❑	Leukemia	❑	❑	Vision Problems
❑	❑	Cerebral Palsy	❑	❑	Intellectual Disability/MR	❑	❑	Other_____

Consent for Treatment:

As the parent or legal guardian of the above patient, I voluntarily give my consent for dental treatment to include exams, cleanings, x-rays, fillings, crowns, nerve treatments, extractions, and space maintenance. I understand that procedures will be discussed with me prior to treatment being rendered. In addition, the information I have given in this medical history is correct. Should there be any changes in my child's health, I will notify the dentist prior to treatment.

Parent/Guardian Signature: _____ Date: _____

Reviewed by Dr.: _____ Date: _____ ASA I II III IV

Parkcrest DENTAL GROUP