Dental History Form

Patient's Name:_____ Date of Birth:_____

Address:_____

Is this the child's first dental appointment? _____ If not when was last appointment?

_____

Has the child had any problem with dental treatment in the past?

_____

Has the child ever suffered from any injuries to the mouth?

_____

Has the child had any problems with the eruption or shedding of teeth?

_____

Has the child had any orthodontic treatment?

_____

Does your household tap water have Fluoride?

_____

Does your child take Fluoride supplements?

_____

Does your child use Fluoride toothpaste?

_____

How many times a day is the child brushing and when?

_____

Does the child use a pacifier or suck their thumb?

_____

At what age did the child stop bottle feeding/Nursing?_____

Is there anything our staff can do to make your child more comfortable during their dental appointment?

_____

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please print name of minor/child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent (s) is covered by insurance with _____ and assign directly to

Name of Insurance Company (ies)

Dr. Rana Mathias/Parkside Dentistry P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

_____ _____

Signature of Parent, Guardian or personal representative — Date

_____ _____

Please print name of parent, Guardian or personal representative — Relationship to patient

_____ _____

Witness — Date

Medical History Form

Patient's Name:_____ Date of Birth:_____

	Y	N	DK
Abuse	☐	☐	☐
ADD/ADHD	☐	☐	☐
Anemia	☐	☐	☐
Anxiety	☐	☐	☐
Apthous Ulcers(canker sores)	☐	☐	☐
Arthritis	☐	☐	☐
Asthma: use of inhaler	☐	☐	☐
Asthma triggers: _____	☐	☐	☐
Autism-Spectrum: _____	☐	☐	☐
Autism:_____	☐	☐	☐
Autoimmune Disorders	☐	☐	☐
Bladder	☐	☐	☐
Bed Wetting	☐	☐	☐
Bleeding Disorders/Hemophilia	☐	☐	☐
Blood Transfusion	☐	☐	☐
Bones/Joints	☐	☐	☐
Cancer	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Chicken Pox	☐	☐	☐
Cleft Lip/Palate	☐	☐	☐
Cold Sores	☐	☐	☐
Congenital Heart Defect	☐	☐	☐
Cystic Fibrosis	☐	☐	☐
Developmental Delays	☐	☐	☐
Depression	☐	☐	☐

	Y	N	DK
Diabetes	☐	☐	☐
Dizziness	☐	☐	☐
Ear Aches	☐	☐	☐
Eating Disorders	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐
Fainting	☐	☐	☐
Gastrointestinal Problems	☐	☐	☐
Growth Problems	☐	☐	☐
Heart Murmur-Innocent	☐	☐	☐
Heart Murmur-SBE needed	☐	☐	☐
Heart Valve Replacement	☐	☐	☐
Endocarditis/Heart Infection	☐	☐	☐
Hay Fever (seasonal allergies)	☐	☐	☐
Hepatitis	☐	☐	☐
High Blood Pressure	☐	☐	☐
HIV/AIDS	☐	☐	☐
Hydrocephalus Shunt	☐	☐	☐
Immunizations	☐	☐	☐
Joint Replacements	☐	☐	☐
Kidney	☐	☐	☐
Latex Allergy	☐	☐	☐
Liver	☐	☐	☐
Measles	☐	☐	☐
Mentally Challenged:_____	☐	☐	☐
Mononucleosis	☐	☐	☐

	Y	N	DK
Mumps	☐	☐	☐
OCD	☐	☐	☐
ODD	☐	☐	☐
Obstructed Sleep Apnea	☐	☐	☐
PDD	☐	☐	☐
Pregnancy (teens)	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Seizures	☐	☐	☐
Sickle Cell Disease/Trait	☐	☐	☐
Snoring	☐	☐	☐
Speech Delay	☐	☐	☐
Spina bifida	☐	☐	☐
Thyroid	☐	☐	☐
Tobacco/Drug use	☐	☐	☐
Tonsil/Adenoid Problems	☐	☐	☐
Venereal Disease	☐	☐	☐
Vision/Eye Problems	☐	☐	☐

Syndrome:_____
_____
_____

OTHER:_____
_____
_____

Are there any other **ILLNESSES** we need to be aware of? If yes please list them below:

_____

_____

Has your child ever had and **SURGERY** including, General Anesthesia, Conscious Sedation, or IV sedation?

_____

_____

Is your child taking any **PRESCRIPTION** and or over the counter **MEDICATIONS** or vitamin supplements at this time? If yes please list below:

_____

Is your child **ALLERGIC** to any **MEDICATIONS** or certain **FOODS** i.e. penicillin, antibiotics, or other drugs? If yes please explain allergy below:

_____

Has your child ever been **HOSPITALIZED** or to the **EMERGENCY** room? If yes please explain below:

_____

Has your child **EVER** had **ANY HEART ISSUES** in the past? If yes please explain below:

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Parents/Guardian Signature:_____ Date:_____

Witness:_____Date:_____