FAMILY DENTISTRY™
DR. TIMOTHY WEBER & DR. MICHAEL OTTO

3223 4th Street SW
Mason City, Iowa 50401
641.424.6461

24 South Hawkeye
Nora Springs, Iowa 50458
641.749.5430

CHILD PATIENT PEDODONTIC HISTORY

Date ______________________

PATIENT INFORMATION *Answers to all Questions are for Office Use and Strictly Confidential*

Name ______________ Home Phone ______________ Cell Phone ______________

Address ______________ City ______________ Zip Code ______________

Sex: M F Birthdate ___/___/___ SS Number ______________

Previous General Dentist (Name, Address & Phone Number) ______________

Reason For Changing Dentist ______________

PARENTS INFORMATION

Fathers Name ______________ SS Number ______________ Birthdate ___/___/___

Cell Phone ______________ Occupation ______________ Employed By ______________

Business Address ______________ Business Phone ______________

Mothers Name ______________ SS Number ______________ Birthdate ___/___/___

Cell Phone ______________ Occupation ______________ Employed By ______________

Business Address ______________ Business Phone ______________

Nearest Friend or Relative (Name & Phone Number) ______________

How Did You Here About Our Office ☐ Friends ☐ Family ☐ Website ☐ Phone Book ☐ Location ☐ Other ______________

INSURANCE INFORMATION

Who Is Responsible For Account ______________

Dental Insurance Company ______________ Subscriber ______________

Insurance ID Number ______________ Group Number ______________

MEDICAL HISTORY

1. Medical Doctor (Name, Address & Phone Number) ______________
2. Is Your Child In Good Health? Yes No Explain: ______________
3. Has He / She Had A Physical Exam In The Last Year? Yes No Date: ______________
4. Is Your Child Now Under Medical Care? Yes No Why: ______________
5. Is He / She Taking Any Medications, Supplements or Drugs? Yes No What: ______________
6. Is He / She Allergic To Any Medications or Substances? Yes No What: ______________
7. Is The Patient Pregnant? (Adolescent Woman) Yes No Due Date: ______________

MARK AN X IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING

☐ Aids / HIV
☐ Allergies
☐ Anemia
☐ Arthritis / Gout
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise Easily
☐ Cancer
☐ Cerebral Palsy
☐ Chemotherapy / Radiation
☐ Cold Sores
☐ Congenital Heart Lesion
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Epilepsy Or Seizures
☐ Excessive Thirst
☐ Fainting Of Dizziness
☐ Fever Blisters
☐ Frequent Cough
☐ Hay Fever
☐ Hearing Disability
☐ Heart Murmur
☐ Heart Surgery
☐ Heart Trouble
☐ Hemophilia
☐ Hepatitis A (Infect.)
☐ Hepatitis B (Serum)
☐ Herpes
☐ High Blood Pressure
☐ Hives or Skin Rash
☐ Hypoglycemia
☐ Kidney Trouble
☐ Liver Disease
☐ Lung Disease
☐ Mental Retardation
☐ Nervousness
☐ Pain In Jaw Joints
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sickle Cell Anemia
☐ Sinus Trouble
☐ Snoring / Sleep Apnea
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ X-ray Or Cobalt Tmt.
☐ Yellow Jaundice

8. Have You Ever Had Any Other Serious Illness Or Condition Not Marked Above? Describe In Detail: ______________ Yes No

____

DENTAL HISTORY

1. Does Your Child Have A Specific Dental Problem? Describe: ________ Yes No

____

2. Does Your Child Have Dental Examinations On A Routine Basis? Date of Last Visit: ________ Yes No

   Last X-Rays: ________ Last Fluoride Tx: ________ Last Cleaning: ________

3. Would You Describe Their Present Dental Health As Good? Comments: ________ Yes No

____

4. Has He / She Been Treated For Any Gum Diseases (Gingivitis, Periodontitis, Trench Mouth, Pyorrhea)? ________ Yes No
5. How Often Does He / She Brush? ________ Floss? ________ Use Mouth Rinses? ________ Yes No
6. Does He / She Feel Nervous About Having Dental Treatment? ________ Yes No
7. Has He / She Ever Had A Bad Experience In A Dental Office? Describe: ________

____

8. Does He / She Ever Brux Or Grind Your Teeth? Discuss: ________ Yes No
9. Has He / She Ever Had Orthodontic Treatment (Tooth Straightening)? ________ Yes No
10. Does He / She Ever Have Clicking, Popping Or Discomfort In The Jaw Joints (TMJ)? ________ Yes No

    Please Discuss: ________
11. Has He / She Had A Root Canal Or Pulpotomy Treatment? ________ Yes No
12. Has He / She Ever Lost A Tooth Due To An Accident Or Decay? ________ Yes No
13. Has He / She Often Had Toothaches? ________ Yes No
14. Has He / She Had Frequent Sores In His / Her Mouth? ________ Yes No
15. Has He / She Had Any Injuries To His / Her Mouth Or Jaw? ________ Yes No
16. Has He / She Ever Had A Thumb Sucking Habit Or Used A Pacifier? ________ Yes No
17. Does He / She Use Tobacco? What Type? ________ Yes No
18. Does He / She Frequently Snack On Sweets, Chew Gum Or Drink Pop? ________ Yes No
19. What Has Been Used For Comfort In Previous Dental Treatment? ☐ Local Anesthetic ☐ N_2O Gas ☐ Neither Yes No
20. Has He / She Had A Reaction To Dental Anesthetic? ________ Yes No
21. Has He / She Been Told They Need To Be Pre-Medicated For Dental Treatment? ________
22. Does He / She Have Any Other Comments Or Concerns That You Would Like To Bring To Our Attention? ________ Yes No

____

23. Do You Wish To Talk To The Doctor Privately About Any Problem? ________ Yes No

X ________ Date ________

Patient Signature (Parent or Guardian)

Reviewed by: Doctor ________ Date ________