CHILD PATIENT PEDODONTIC HISTORY

FAMILY DENTISTRY™
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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. Has He / She Ever Been Hospitalized or Had A Major Operation?	Yes	No	Explain: _____
6. Has He / She Ever Had A Serious Head or Neck Injury?	Yes	No	Explain: _____
7. Is He / She Taking Any Medications, Supplements or Drugs?	Yes	No	What: _____
8. Is He / She Allergic To Any Medications or Substances?	Yes	No	What: _____
9. 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	☐ Cancer	☐ Excessive Thirst	☐ Hemophilia	☐ Lung Disease	☐ Sinus Trouble
☐ Allergies	☐ Cerebral Palsy	☐ Fainting Of Dizziness	☐ Hepatitis A (Infect.)	☐ Mental Retardation	☐ Snoring / Sleep Apnea
☐ Anemia	☐ Chemotherapy / Radiation	☐ Fever Blisters	☐ Hepatitis B (Serum)	☐ Nervousness	☐ Thyroid Disease
☐ Arthritis / Gout	☐ Cold Sores	☐ Frequent Cough	☐ Herpes	☐ Pain In Jaw Joints	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Congenital Heart Lesion	☐ Hay Fever	☐ High Blood Pressure	☐ Psychiatric Care	☐ Ulcers
☐ Asthma	☐ Cortisone Medicine	☐ Hearing Disability	☐ Hives or Skin Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Blood Disease	☐ Diabetes	☐ Heart Murmur	☐ Hypoglycemia	☐ Rheumatism	☐ X-ray Or Cobalt Tmt.
☐ Blood Transfusion	☐ Drug Addiction	☐ Heart Surgery	☐ Kidney Trouble	☐ Scarlet Fever	☐ Yellow Jaundice
☐ Bruise Easily	☐ Epilepsy Or Seizures	☐ Heart Trouble	☐ Liver Disease	☐ Sickle Cell Anemia	

CONTINUED FROM PREVIOUS QUESTION

10. Have You Ever Had Any Other Serious Illness Or Condition Not Marked? 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 _____