PEDODONTICS, P.C.
PATIENT MEDICAL HISTORY

Today's Date:_____ *To Be Completed by Parent(s) or Guardian(s)*
PLEASE COMPLETE FRONT AND BACK IN FULL

So that we may know and better understand your child, and be prepared to render the best possible service, it is requested that you *fully* complete the front and back side of this form.

Child's Full Name: _____Nickname:_____

Date of Birth (MM/DD/YY): _____ Age Today: _____ Sex: Male or Female

Ages of Brother(s) ( ) ( ) ( ) ( ) Ages of Sister(s) ( ) ( ) ( ) ( )
Child's Physician: _____ Physician's Phone #: _____
Family Dentist: _____ Child's last dental visit (*If applicable*): _____

The following questions are of great value in aiding us in the treatment of your child.

1. Does your child have any specific medical condition – ex: *Tuberculosis, Cancer, Cerebral Palsy, etc*.? YES NO
   If so, please specify_____
2. Does your child have any special limitations either mental or physical? YES NO
   If so, please specify_____
3. Has your child ever tested positive for *Hepatitis* or *HIV*? If so, please specify_____ YES NO
4. Has either natural parent ever tested positive for *Hepatitis* or *HIV*? YES NO
   If yes, please specify parent and condition_____
5. Does your child have any allergies? ex: *medications, foods, LATEX, dyes, local anesthetics*? YES NO
   If so, please specify_____
6. Is your child taking <u>any</u> medicine or under a physician's care, now, for any reason? YES NO
   If so, please specify_____
7. Has your child had any history of *thumb sucking, finger sucking, lip sucking, pacifier use or nail biting*? YES NO
   If so, please specify_____
8. Was your child *breast fed*? _____ *Bottle fed*? _____ Any difficulties? _____
9. Has your child ever had an unfavorable experience in a medical or dental office? YES NO
10. Has your child ever had any injuries to the teeth, mouth, head or neck? YES NO
    If so, please specify_____
11. Has the child's natural parents ever had a lot of decay or crooked teeth? YES NO
12. Does your child have a history of any of the following?

Anemia	YES	NO	Asthma	YES	NO
Bleeding Disorder	YES	NO	Brain or Nerve Disorder	YES	NO
Diabetes	YES	NO	Epilepsy	YES	NO
Fainting Spells	YES	NO	Respiratory infections	YES	NO
Rheumatic Fever or Heart Disorder	YES	NO	Other_____		

13. Has your child had a toothache lately? If so, was the toothache after eating? _____ YES NO
    If so, for how long? _____Did it awaken the child from sleep? _____
14. How do you think your child will react to this dental visit?
    Please check one: Very Poorly_____ Poorly_____ Well_____ Very Well_____
15. Purpose of today's visit: _____

PLEASE TURN FORM OVER AND COMPLETE BACK SIDE

Whom may we thank for referring you to this office?_____

Please complete the following (*print neatly*):

Parents' Marital Status: (please circle one) single married widowed separated divorced

Parent's Name_____

Date of Birth (MM/DD/YY):_____

Home Phone #_____

Address_____

City_____

State_____ Zip_____

Parent's Employer_____
Occupation_____
Address_____
_____

Work Phone #_____

Parent's Social Security #_____

Parent's Name_____

Date of Birth (MM/DD/YY):_____

Home Phone #_____

Address_____

City_____

State_____ Zip_____

Parent's Employer_____
Occupation_____
Address_____
_____

Work Phone #_____

Parent's Social Security #_____

Person(s) responsible for payment of this account: ( ) Parents ( ) Other_____
If you checked *Other* and that person's billing address was not listed above, please do so below.
□ Self Pay □ Medicaid

Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____

Is the child covered by **dental** insurance? ( ) YES ( ) NO

Name of insurance subscriber (parent)_____
Employer/Private policy_____
Subscriber ID#_____Group #_____
Name of insurance co. and claims address_____

Because the child is a minor, it becomes necessary that a signed permission is obtained from the parent or guardian before any and all dental care can be accomplished by **Pedodontics, P.C.**- Dentistry for Children and Young Adults. This signed form gives said permission to perform all necessary procedures to restore and maintain the child's Dental Health. I/We certify the truth of all personal information contained in this form and the patient information is absolute. In order to facilitate the processing of any insurance claim for the aforementioned patient, I/We agree to the release of any information relating hereto.

It is Pedodontics, P.C. policy that patients have bitewing x-rays to check for decay every year and a panoramic x-ray once every 3 years. Please let us know if you would prefer that we only take x-rays with your permission

I/We agree to be financially responsible for any bill incurred on this patient.

_____ _____
Signature(s) of Parent or Guardian Date

For Office Use Only: DOCTOR_____ ACCOUNT_____

□ SCND □ ICDSCND _____OFFICE STAFF INITIALS