

# ABC Pediatric Dentistry

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Birthdate \_\_\_\_\_  Male  Female Does the patient speak English?  Yes  No

Name of person completing this form \_\_\_\_\_ Relationship to Patient:  Mother  Father  Other \_\_\_\_\_

Patient lives with  Both Parents  Mother  Father  Other \_\_\_\_\_

## DENTAL HISTORY

Is this the patient's first dental visit?  No  Yes; Date of last visit \_\_\_\_\_ Reason for today's visit \_\_\_\_\_

Is the patient in pain?  Yes  No

Has the patient ever had any of the following:

YES NO

Thumb or finger sucking, nail biting, etc.

Pacifier, bottle in bed

Orthodontics or appliances

YES NO

Grinding or clenching of teeth

Fluoride supplements

In general, what has the patient's past dental experience been? Good Average Poor

## MEDICAL HISTORY

Name of patient's Physician \_\_\_\_\_ Clinic \_\_\_\_\_

YES NO

Is the patient currently under medical care? Reason(s) \_\_\_\_\_

Taking medications?

Ever had surgery or been hospitalized overnight?

Explain \_\_\_\_\_

Ever had a blood transfusion yes, Date \_\_\_/\_\_\_/\_\_\_

Does patient have any Tubes, Shunts, or Prostheses?

If yes, explain; \_\_\_\_\_

Allergies; Latex, Food, Medications etc. If yes, please list \_\_\_\_\_

AIDS/ HIV

Asthma

Behavior problems

Blood disorder  Anemia  Hemophilia  Sickle cell anemia

Other \_\_\_\_\_

Cancer

Cerebral Palsy

YES NO

Chicken Pox  recent exposure

Diabetes, medication \_\_\_\_\_

Epilepsy, Seizures, Medications? \_\_\_\_\_

Hepatitis or Liver disease/ exposure

Heart Disease

Explain:  Murmur  Congenital Defect  History of rheumatic fever

Hearing Loss

Kidney Disease

Learning disability

Measles

Mental Retardation, Functional age level \_\_\_\_\_

Pregnancy

Skin Rash

Sinus Problems

Thyroid Condition

Tuberculosis / exposure

I certify that I have read and understand the above. I acknowledge that my questions if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Allen, or any members of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Parent/ Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_