CHILD MEDICAL AND DENTAL HISTORY *one form needed per child*

PATIENT LEGAL NAME: ________________________________ NICKNAME: ____________________

DATE OF BIRTH: ______________ GENDER: ___________ SEX: (This is for insurance purposes only) Male Female

IS CHILD ADOPTED? Yes No *If yes, do they know?* Yes No

DENTAL HISTORY

What is the primary reason for today's visit? Cleaning/Exam Trauma/Dental Emergency Consult for Decay (Cavities) Second Opinion

Has your child ever been to the dentist? Yes No If yes, Previous/Present Dentist Name: ____________________

Date of Last Dental Exam: ____________________ Date of last X-rays (if known): ____________________

Has patient had an injury to the mouth, teeth, or jaw? Yes No If yes, explain: ____________________

Describe your child: Outgoing Shy Stubborn Anxious Frightened Age-Appropriate

How would you expect your child to behave in our office? ____________________

How may we help make this visit a positive experience for your child? ____________________

Does your child currently… *(please check all that apply)*

Suck thumb / finger Suck/bite lips Bite/chew nails Bottle Feed: Until what age? ____________________

Use pacifier Clench/grind teeth Breathe through mouth primarily Breast Feed: Until what age? ____________________

HYGIENE ROUTINE *(please check all that apply)*

Fluoride toothpaste Consume Fluoridated Water Fluoride Mouthwash Fluoride Supplement Other: ____________________

Brushing by Child: _____/day Brushing by Parent: ______/day Dental Floss: _____/week Gummy vitamins?

Snacks between meals – *Type of snacks:* ____________________ Cups of Juice: _____/day

MEDICAL HISTORY

Physician Name: ____________________ Physician Phone: ____________________

Date of Last Medical Check-up: ____________________ Immunizations up to date? Yes No

Does patient have, or had any of the following? None of the below

Acid reflux (GERD)	Eating Disorder	Mental Disorder / Cognitive Delay
ADD / ADHD	Emotional Disturbances	Premature / Low birth weight
Anxiety / Depression	Epilepsy / Seizures / Convulsions	Rheumatic fever (or any history)
Asthma / Reactive Airway Disease	Hearing Problems / Deaf	Sleep Apnea
Autism Spectrum	Heart defect / heart surgery	Special Needs
Bleeding Disorder / Anemia	Heart murmur	Speech Disorder / Delay
Cancer / Tumor / Leukemia	Hemophilia / Abnormal Bleeding	Stomach / GI Disorders
Cerebral Palsy	History of Abuse	Visual impairment (excluding glasses)
Cleft Lip / Cleft Palate	Immune Disorder / HIV/AIDS	Other:
Congenital Birth Defects	Kidney Problems	
Developmental Disorders	Liver Disease / Jaundice / Hepatitis	
Diabetes	Low / high blood pressure	

*If you have checked **yes** to any of the above medical conditions, please explain:*

ALLERGIES

No known allergies

Medications: ____________________ Latex Food: ____________________ Seasonal Hives

Other (please specify): ____________________ *Comments / Details*: ____________________

IS PATIENT TAKING ANY MEDICATIONS?

YES NO *Please list all medications and natural remedies*

Medication Name: ____________________ Dose: ______________ Frequency of Use: ____________________

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Has patient had surgery or been hospitalized? Yes No

Hospital Facility: ____________________ Reason: ____________________ Date: ______________

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The information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I understand that it is my responsibility to inform Acorn Dentistry for Kids of any changes in medical status.

Guardian Signature: ____________________ Relationship to Patient: ______________ Date: ___________ Dr Initials: _______

Guardian Signature: ____________________ Relationship to Parent: ______________ Date: ___________Dr. Initials: _______

Guardian Signature: ____________________ Relationship to Parent: ______________ Date: ___________Dr. Initials: _______

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