Patient Dental/Medical History Form

Pediatric SMILES
DENTISTRY FOR CHILDREN AND TEENS

Thank you for choosing Pediatric Smiles for your child's dental needs. Please fill out this form completely in order to help us understand and care for your child better. If you have any questions or concerns, please do not hesitate to ask for assistance.

Patient Name _____ **Date** _____

Dental History

What is the reason for today's visit? _____
Is this the child's first visit to a dentist? ☐ Yes ☐ No If no, when was the last dental visit? _____
Former dentist, if any? _____ Phone _____
Has the child ever had dental radiographs (x-rays)? ☐ Yes ☐ No
Has your child ever had any injuries to the mouth, head or teeth? _____
Has your child ever had any problem with dental treatment in the past? _____
Has your child had any orthodontic treatment? _____
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water
Has your child received fluoride supplement? ☐ Yes ☐ No If yes, at what age? _____
How many times are the child's teeth brushed per day? _____ When: _____
Has the child sucked his/ her thumb, fingers or pacifier? ☐ Yes ☐ No Does the habit still exist? ☐ Yes ☐ No
At what age did your child stop bottle feeding? _____ Does the child grind his/ her teeth? ☐ Yes ☐ No
Please describe your child temperament? ☐ Friendly ☐ Talkative ☐ Quiet/shy ☐ Unmanageable
☐ Nervous ☐ Active ☐ Independent ☐ Aggressive ☐ Stubborn ☐ Insecure ☐ Strong-willed ☐ Whiney

Medical History

1. Is your child taking any prescription and/ or over the counter medications? ☐ No ☐ Yes
   If yes, please list _____
2. Is your child allergic to any medication? ☐ No ☐ Yes
   If yes, please list _____
3. Is your child allergic to any foods or materials? ☐ No ☐ Yes
   If yes, please list _____
4. Has your child been hospitalized? ☐ No ☐ Yes
   When? _____ Reason? _____
5. Has your child ever been a patient at the emergency room? ☐ No ☐ Yes
   When? _____ Reason? _____
6. Has your child had general anesthesia? ☐ No ☐ Yes
   Any complications with general anesthesia? _____
7. Has your child had any history or ever been diagnosed with any of the following:

☐ Anemia	☐ Brain injury	☐ Hearing loss/aids/implants	☐ Mumps
☐ Allergy/ Hay fever	☐ Brain surgery	☐ Heart murmur	☐ Pneumonia
☐ Arthritis/ Rheumatism	☐ Cancer, type _____	☐ Heart problem/surgery	☐ Polio
☐ Artificial heart valve	☐ Cerebral Palsy	☐ Hemophilia	☐ Pregnancy
☐ Artificial joint/ limb	☐ Chemotherapy	☐ Hepatitis	☐ Rheumatic fever
☐ Asthma	☐ Chicken Pox	☐ High/ low blood pressure	☐ Scarlet fever
☐ Attention Deficit Disorder	☐ Chronic sinusitis	☐ HIV+/AIDS	☐ Scoliosis
☐ Autism	☐ Cleft lip/ palate	☐ Hormonal disturbances	☐ Shunt
☐ Behavior/ Learning Disabilities	☐ Diabetes	☐ Kidney problems	☐ Tetanus
☐ Epilepsy/seizure	☐ Digestive disturbances	☐ Liver problems	☐ Tuberculosis
☐ Birth defects	☐ Eye problems	☐ Malignant hyperthermia	☐ Venereal disease
☐ Bleeding Disorder	☐ Fainting	☐ Measles	☐ Whooping cough
☐ Bone/Joint/orthopedic problem	☐ Growth problem	☐ Mental retardation	☐ Other _____

Pediatrician/ Physician Name _____ Phone _____
Address _____
Please list other specialists your child may be seeing:
1. _____ Address _____ Phone _____
2. _____ Address _____ Phone _____