ABC Pediatric Dentistry

PATIENT INFORMATION

Date_____
Patient Full Name:_____ Preferred Name:_____Birthday_____ □ 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 patients 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	YES NO
□ □ Thumb or finger sucking, nail biting, etc.	□ □ Grinding or clenching of teeth
□ □ Pacifier, bottle in bed	□ □ Fluoride supplements
□ □ Orthodontics or appliances	

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

MEDICAL HISTORY

Name of patients Physician_____Clinic_____

YES NO	YES NO
□ □ Is the patient currently under medical care? Reason(s)_____	□ □ Cognitive Delay, Functional age level_____
□ □ Taking medications?	□ □ Diabetes, medication_____
□ □ Ever had surgery or been hospitalized overnight? Explain_____	□ □ Epilepsy, Seizures, Medications?_____
□ □ Ever had a blood transfusion yes, Date___/___/___	□ □ Hepatitis or Liver disease/ exposure
□ □ Does patient have any Tubes, Shunts, or Prostheses? If yes, explain;_____	□ □ Heart Disease? Explain: □ Murmur □ Congenital Defect □ History of rheumatic fever
□ □ Allergies; Latex, Food, Medications etc. If yes, please list_____ _____	□ □ Hearing Loss
□ □ AIDS/ HIV	□ □ Kidney Disease
□ □ Asthma	□ □ Learning disability
□ □ Behavior problems	□ □ Measles
□ □ Blood disorder □ Anemia □ Hemophilia □ Sickle cell anemia □ Other _____	□ □ Pregnancy
□ □ Cancer	□ □ Skin Rash
□ □ Cerebral Palsy	□ □ Sinus Problems
□ □ Chicken Pox □ recent exposure	□ □ 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, Dr. Kurt, 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 ___/____/____