Medical History Reviewed with

_____

By_____

HIGHLAND
Pediatric Dental
Where first smiles begin!

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Chart #_____

Health Alerts_____

_____

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name:_____ Nickname:_____ Date of Birth:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ SS#:____-____-____ Age:_____ Sex: Male Female (circle)

Father/Legal Guardian:_____ Relation to Patient:_____
Employer:_____ Work #:_____ Mobile #:_____
Date of Birth:_____ SS#:____-____-____ Drivers License #:_____ State:_____

Mother/Legal Guardian:_____ Relation to Patient:_____
Employer:_____ Work #:_____ Mobile #:_____
Date of Birth:_____ SS#:____-____-____ Drivers License #:_____ State:_____

Who has **legal** custody?_____ Person responsible for payment of account:_____
_____Are parents and child living together?_____ Comments:_____
_____Dental Insurance: q Yes q No Insurance Company:_____ Member ID #:_____
If Medicaid, child's number and country:_____
Whom can we thank for referring you to us?_____
Address:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Mobile:_____

MEDICAL HISTORY

Child's Physician /Pediatrician:_____ Phone #:_____
Mailing Address:_____ City:_____ State:_____ Zip:_____

❑ Yes ❑ No Is your child in good health? Date of last physical exam_____
❑ Yes ❑ No Has your child ever had a health problem?_____
❑ Yes ❑ No Is your child allergic to anything? If yes, what?_____
❑ Yes ❑ No Is your child currently taking any medications? Please give medication, dose, and reason:

_____

❑ Yes ❑ No Are your child's immunizations current?_____
❑ Yes ❑ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:

_____

Do you feel your child is: ❑ a slow learner ❑ progressing normally ❑ a fast learner

Please check if your <u>child</u> has been treated for any of the following:

❑ Heart Disease	❑ Asthma/breathing	❑ Speech/hearing	❑ Seizures	❑ Heart Murmur
❑ Cleft lip/palate	❑ADHD/ADD	❑ Congenital birth defects	❑ Anemia	❑ Tonsil/adenoid problems
❑ Mental delays	❑ Pregnant	❑ Blood dyscrasias	❑ Snoring	❑ Personality/social
❑ Frequent Infections	❑ Tuberculous	❑ Abuse	❑ Cerebral palsy	❑ Seasonal Allergies
❑ Sickle cell disease/trait	❑ Cancer/tumors	❑ Autism	❑ Latex Allergies	❑ Diabetes
❑ Liver/GI disease	❑ Endocrine/growth	❑ Food Allergies	❑ Hepatitis	❑ Kidney Disease
❑ Spina bifida	❑ Recurrent headaches	❑ AIDS	❑ Rheumatic fever	❑ Shunts ❑ Eyesight

Other_____
Has any member of your child's family had any of the above? If yes, please explain_____

_____

DENTAL HISTORY

What is the reason for your child's dental visit?

❑ Yes ❑ No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken)

Name of previous dentist?_____Phone_____

❑ Yes ❑ No Has your child experienced any unfavorable reaction from previous dental care?_____

❑ Yes ❑ No Has your child had a local anesthetic?_____

❑ Yes ❑ No Has your child been sedated for dental treatment?_____

❑ Yes ❑ No Have your child's teeth ever been injured?_____

❑ Yes ❑ No Has your child had any treatment for dental trauma?_____

❑ Yes ❑ No Does your child suck a finger, thumb or pacifier?_____

❑ Yes ❑ No Does you child go to bed with a bottle or sippy cup?_____

❑ Yes ❑ No Does your child smoke or chew tobacco?_____

Name and ages of other children in your family_____

Please check if your child is having problems with any of the following:

❑ Cavities ❑ Toothache ❑ Sensitive teeth ❑ Mouth Breathing ❑ Trauma ❑ Gum Infections

❑ Color of Teeth ❑ Orthodontics ❑ Jaw Sounds ❑ Grinding of Teeth

❑ Other_____

Comments:_____

FLUORIDE HISTORY

❑ Yes ❑ No Is your home water supply fluoridated? If yes name of company_____

❑ Yes ❑ No Does your child use a fluoride toothpaste?

❑ Yes ❑ No Do you give your child any other forms of fluoride? If yes what?_____

❑ Yes ❑ No Does your child participate in a school fluoride rinse program?

LEGAL CONSENT FORM

I give my permission for the following individuals to bring my child to the dentist.

1) Name_____Relationship_____Phone #_____

2) Name_____Relationship_____Phone #_____

3) Name_____Relationship_____Phone #_____

I am fully aware that the treatment and fees may change and payment is expected in full at the time of service. The treatment plan has explained to me and the office staff has answered all questions. I also give this person permission to consent to protective stabilization in a papoose board if necessary. I also understand that I need to be reached by phone while my child is in the dental office.

If we cannot reach you for permission, service may not be rendered if someone else brings your child for treatment.

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information listed on both sides of this form is complete and accurate. I give consent for Dr. Yvette Stokes, Dr. Phillip Caldwell, Associate dentists and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform *Highland Pediatric Dentistry of any changes in my child's medical status.*

Legal Guardian's Signature:_____**Date:**_____

Observation notes:_____

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