Patient Information and Medical History

972.608.4746
972.608.4749 fax

Child Legal Name: _____ Preferred Name: _____

Date of Birth _____/_____/_____ Age: _____ Weight: _____ ☐ Male ☐ Female

Home Address: _____ Apt. # _____

City: _____ State: _____ Zip code: _____

School: _____ District: _____ Grade: _____

Have sibling(s) been seen in this office? ☐ Yes ☐ No

Name(s) of sibling(s): _____

***WHOM MAY WE THANK FOR REFERRING YOU TO US?**

☐ Pediatrician/Doctor ☐ Friend

☐ Internet ☐ Other

Name: _____

EMERGENCY CONTACT (other than parents)

Name: _____

Relationship: _____

Phone #: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone #_____

Mailing Address: _____City: _____ State: _____ Zip: _____

DENTAL HISTORY

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

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?
Explain:_____

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

☐Yes ☐No Does your child have pain when chewing, yawning, or wide opening?

☐Yes ☐No Does your child go to bed with a bottle or sippy cup?

☐Yes ☐No Does your child snack frequently? What are their favorite snack(s) foods? _____

☐Yes ☐No Has your child had local anesthetic? Were there any problems? _____

☐Yes ☐No Has your child been sedated for dental treatment? Were there any problems?
Explain (if yes) _____

☐Yes ☐No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

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

☐Cavities ☐Toothache ☐Sensitive Teeth ☐Mouth Breathing ☐Trauma
☐Gum Infections ☐Color of Teeth ☐Jaw Sounds ☐Grinding of Teeth

Comments:

_____

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MEDICAL HISTORY

Is your child allergic to:

☐ Penicillin ☐ Latex ☐ Aspirin ☐ Local Anesthetic (Lidocaine)
☐ Foods: _____ ☐ Other (including OTC)_____

☐ 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 Are your child's immunizations current?
☐ Yes ☐ No Is your child currently taking any medications? Please list medication, dose & reason:
_____
☐ Yes ☐ No Have you ever been told that your child needs to take antibiotics before dental treatment?
☐ Yes ☐ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
Explain: _____

Do you consider your child to be:

☐ advanced in the learning process
☐ progressing normally
☐ slow in the learning process

Please check if your child has been treated for any of the following:

☐ Abuse	☐ Cancer/Tumors	☐ Heart Murmur	☐ Recurrent herpes/fever blisters
☐ ADD/ADHA	☐ Cerebral palsy	☐ Hepatitis	☐ Rheumatic fever
☐ AIDS	☐ Cleft lip/palate	☐ Kidney Disease	☐ Seizures
☐ Anemia	☐ Congenial birth defects	☐ Liver/GI Disease	☐ Sickle cell disease/trait
☐ Anxiety Disorder	☐ Diabetes	☐ Mental Delays	☐ Significant Injuries
☐ Arthritis	☐ Endocrine	☐ Personality Disorder	☐ Snoring
☐ Asthma/Breathing	☐ Eyesight	☐ Social Disorder	☐ Speech/Hearing
☐ Autism	☐ Frequent Infections	☐ Physical Delays	☐ Tonsil/Adenoid Problems
☐ Bleeding/transfusions	☐ Heart Disease	☐ Recurrent Headaches	☐ Tuberculosis

Other:

_____

If any boxes checked, please describe further:

_____

CONSENT FOR DENTAL TREATMENT

I certify that I have read and understand the above information on this form to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also understand it is very important to report any changes in my child's medical or dental status to the dentist at the earliest possible time, and I agree to do so.

I give consent for Grin Central Station LLP to perform dental treatment on my child.

I understand I will be responsible for any charges incurred for my child for dental treatment.

Signature _____ Date _____

Relationship to Patient: _____