



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? EMERGENCY CONTACT (other than parents)

Pediatrician/Doctor Friend Name:
Internet Other Relationship:
Name: 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:
Has your child experienced any unfavorable reaction from previous dental care? Explain:
Does your child suck a finger, thumb, or pacifier?
Does your child have pain when chewing, yawning, or wide opening?
Does your child go to bed with a bottle or sippy cup?
Does your child snack frequently? What are their favorite snack(s) foods?
Has your child had local anesthetic? Were there any problems?
Has your child been sedated for dental treatment? Were there any problems? Explain (if yes)
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:

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