PEDIATRIC PATIENT MEDICAL - DENTAL FORM

Name of Child: _____ Date of Birth: _____ Date: _____
Last First Mid. Int.

Nickname: _____ Sex: _____

Mailing Address: _____ Home Phone: _____

Parent's Place of Employment: _____ Business Phone: _____

Name of Parent or Legal Guardian: _____

Father's Name: _____ Social Security Number: _____ Date of Birth: _____

Mother's Name: _____ Social Security Number: _____ Date of Birth: _____

Person Responsible for this Account: _____

Brothers (Names and Ages): _____

Sisters (Names and Ages): _____

Pets: _____ Hobbies: _____

Who May We Thank for Referring You To This Office? (Name and Address): _____

CHILD'S MEDICAL HISTORY

Child's Medical Doctor: _____ Address: _____

Phone: _____ Approximate Date of Last Physical Examination: _____

	YES	NO
1) Is your child under a medical doctor's care now?	☐	☐
2) Is your child taking **any** drugs or medications?	☐	☐
3) Has your child ever had unfavorable reactions to any foods, drugs or medications (e.g, penicillin and novocaine)?	☐	☐
4) Has your child ever been hospitalized or seriously injured?	☐	☐
5) Does your child have any limitation to sports activities?	☐	☐
Does your child have any history of the following:		
6) A heart ailment or murmur?	☐	☐
7) High or low blood pressure?	☐	☐
8) Respiratory disease?	☐	☐
9) Diabetes?	☐	☐
10) Rheumatic fever?	☐	☐
11) Any blood disease or bleeding problems?	☐	☐
12) Liver disease?	☐	☐
13) Kidney disease?	☐	☐
14) Stomach or intestinal disease?	☐	☐
15) Tumors or growths?	☐	☐
16) Hepatitis?	☐	☐
17) Tuberculosis?	☐	☐
18) Growth problems?	☐	☐
19) Mental problems?	☐	☐
20) Acquired Immune Deficiency (AIDS)?	☐	☐
21) Recurrent herpes infections, like cold sores?	☐	☐
22) Frequent headaches?	☐	☐
Does your child have problems in:		
23) Concentrating?	☐	☐
24) Learning?	☐	☐
25) Understanding?	☐	☐
26) Does your child have speech problems?	☐	☐
27) Does your child have any implants, e.g., a hip or artificial heart valve?	☐	☐
28) Is your child on a special diet?	☐	☐
29) Has your child had night sweats accompanied with weight loss and cough?	☐	☐
30) Has your child's skin or the whites of the eyes ever become yellow or jaundice?	☐	☐

(OVER)

	YES	NO
31) Have any of your child's wounds healed slowly or presented other complications?	☐	☐
32) Has your child ever experienced any dizziness, fainting spells or seizures?	☐	☐
33) Is there any medical problem not mentioned above that we should know about your child?	☐	☐
34) Is there any reason that you **do not** consider your child to be in good health at this time?	☐	☐

35) Please fully explain any yes answer from above, e.g. list medications, allergies, etc.

CHILD'S DENTAL HISTORY

	YES	NO
1) Is this the child's first visit to a dentist?	☐	☐
If no, when was the date of the last examination _____		
Has your child ever had any of the following oral health concerns:		
2) Frequent sore throats and/or ear aches?	☐	☐
3) Snoring?	☐	☐
4) Tonsils or Adenoids removed?	☐	☐
5) Popping or clicking when the mouth is opened?	☐	☐
6) Spaced, crooked or protruding teeth?	☐	☐
7) Clenching or grinding teeth?	☐	☐
8) Finger or thumb habits (sucking, nail biting, etc.)?	☐	☐
9) Mouth breathing?	☐	☐
10) Other, Please list: _____	☐	☐
11) Has your child received treatment for orthodontics (braces), temperomandibular joint (TMJ) or periodontal (gum) problems?	☐	☐
12) Does your child have any sores, unhealed injuries or inflamed areas in or around the mouth?	☐	☐
13) Has your child ever had any reaction or allergic symptoms to novocaine?	☐	☐
14) Has your child ever had nitrous oxide (laughing gas) inhalation analgesia?	☐	☐
15) Has this child ever had any unfavorable reaction to nitrous oxide inhalation analgesia?	☐	☐
16) Does your child have any dental complaints at this time? Please explain: _____	☐	☐

17) Please explain YES answers from above: _____

IF YOU ARE COVERED BY **DENTAL INSURANCE**, COMPLETE THE FOLLOWING:

1) Name of employer providing group dental insurance for you: _____

2) Name of the dental insurance company: _____

3) Name, birth date and social security number of family member who holds dental policy with insurance company: _____

_____

IF YOU ARE COVERED BY **SOCIAL SERVICE**, PLEASE COMPLETE THE FOLLOWING:

1) Name of county where child is covered through: _____

2) Child's social security number: _____

3) Child's case number: _____

IF YOU ARE COVERED BY A **CAFETERIA/FLEXIBLE SPENDING ACCOUNT** OR **IRS CODE SECTION 125 PLAN**, PLEASE NOTIFY US SO WE MAY BEST ASSIST YOU WITH YOUR TREATMENT PLANS.

☐ YES ☐ NO

I certify that all above statements made for my child have been answered truthfully and to the best of my knowledge. I hereby give permission for my child to be examined and treated by Dr. Swanson and his staff.

Signature: _____