Medical History

Patient's Primary Care Physician: _____ Phone: _____

Does your child see any other medical specialist for other conditions? If so, please list names and contact information: Physician specialty/sub specialist (cardiologist, neurologist, etc.):

Name: _____ Phone: _____

How would describe your child's overall health? ☐ Excellent ☐Good ☐Fair ☐ Poor

When was your child's last physical? ☐ 0-3 months ☐3-6 months ☐6 months ☐Year

Has your child ever been hospitalized for surgical procedures? ☐Yes ☐No

Has your child ever been hospitalized for non-surgical procedures? ☐Yes ☐ No

Is your child currently taking any medications (include herbals and over the counter meds) ☐Yes ☐No

If Yes, List & Explain: _____

Has your child ever had any of the following?

☐Autoimmune Disorder
☐Down Syndrome
☐Blood or Bleeding Disorder
☐Asthma
☐Hormone, Kidney or Liver Problems
☐Behavior Issues (AD/HD, etc.)
☐Diabetes Type I or II
☐Bone or Joint Problems
☐Nervous Disorder (Seizures/Epilepsy)
☐Digestion Problems
☐Cancer/Chemotherapy/Radiation
☐Hydrocephalus
☐Innocent Heart Murmur
☐Muscular Problems
☐Neurological Disorders
☐HIV/AIDS
☐MTHFR Gene Mutation
☐Autism Spectrum
☐Surgeries (List Below)
☐Vision/Hearing Impaired
☐Congenital Heart Defects
☐Other (Please list below)
☐Allergies (Please list below)

_____

If you circle/answered yes to any medical condition above or if your child has any other medical condition not listed, please explain:_____

_____

Dental History

Reason for visit? _____ Is this your child's first visit ever? ☐ Yes ☐ No

If No, date of last visit? _____ Name of former dentist: _____

Date of last x-rays: _____ Treatment performed: _____

Was your child breast fed? ☐Yes ☐No If yes, until what age? _____

Was your child bottle fed? ☐Yes ☐ No If yes, until what age? _____

Has your child ever had any injuries to his/her teeth, mouth, head or jaws? ☐Yes ☐No

If Yes, please describe including any treatment performed: _____

Does your child drink juice or soda most days? ☐Yes ☐ No

Eat sweets, chips, gummies/fruit snacks? ☐Yes ☐ No

Does your child brush daily? ☐ Yes ☐No Does an adult assist with brushing? ☐Yes ☐No

Does your child floss daily? ☐Yes ☐No Does an adult assist with flossing? ☐Yes ☐No

Does your child have any of the following habits?

☐ Finger sucking ☐ Nail biting ☐ Teeth grinding
☐ Pacifier ☐ Lip sucking ☐ Mouth breathing

Does your child receive fluoride in any of the following forms?

☐Vitamins ☐ Toothpaste ☐ Water supply ☐Tablets/Drops/Rinse/Gel

Has your child had any negative dental or medical experience in the past? ☐Yes ☐No

If Yes, explain: _____

Please check any of the following that may describe your child:

☐Anxious ☐ Cooperative ☐ Curious ☐Defiant ☐ Hyper
☐Mellow/Shy ☐ Stubborn ☐Trusting ☐ Outgoing

How can we make this a more a positive experience for your child?

_____

Emergency Contact:

Name: _____

Phone: _____ **Relationship to patient:_____**

<u>Desert Kids Dentistry Health History Acknowledgment</u>

I understand that the information that I have given and submitted to Desert Kids Dentistry is correct to the best of my knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform Desert Kids Dentistry of any changes to my child's medical status. I authorize Dr. Steven Petruzzi and ancillary staff to perform the necessary dental services my child may need.

Print Name_____ **Signature_____**

Relationship to Patient_____ **Date_____**

Doctor's Signature_____ **Date_____**

Patient Name:_____