



Upstate Pediatric Dentistry

Medical and Dental History

Patient's Name _____ Date of birth _____ Age _____ Male Female

MEDICAL HISTORY

Physician _____

Yes No

- () () Is patient in good health?
- () () Is patient under a physician's care? For what? _____
- () () Does patient have any history of major illness? What? _____
- () () Has patient ever been hospitalized? For what? _____
- () () Is the patient receiving any medication/drugs presently? Please give medications and reason. _____
- () () Does patient have any allergies or drug sensitivity? Please list. _____
- () () Does patient have a tendency to colds (), sore throat (), ear infections (), sinus congestion (), breathing problems ()?
- () () Have tonsils and/or adenoids been removed? What age? _____

Check any of the following conditions for which the patient has been treated:

- | | | |
|---------------------|------------------------|----------------------------|
| () ADD/ ADHD | () Epilepsy/Seizures | () Liver/Kidney Disease |
| () AIDS | () Emotional Problems | () Nutritional Problems |
| () Asthma | () Endocrine Problems | () Prolonged Bleeding |
| () Autism | () Fainting/Dizziness | () Rheumatic Fever |
| () Blood Disorders | () Heart Problems | () Sickle Cell Anemia |
| () Cerebral Palsy | () Hepatitis | () Speech/Hearing Problem |
| () Diabetes | () HIV Positive | () Tuberculosis |

Any other significant medical, psychological, or disability problems? _____ Please describe. _____

DENTAL HISTORY

Previous Dentist _____

Yes No

- () () Have there been any injuries to the face, mouth or teeth? _____
- () () Has the patient ever sucked his/her thumb or fingers? Until what age? _____
- () () Does the patient have any speech problems? _____
- () () Is the patient a "mouth breather"? While awake? _____
- () () Does the patient have noticeable problems in chewing or swallowing? _____
- () () Any clicking, popping, or discomfort upon opening or closing their mouth? _____
- () () Does the patient see a dentist regularly? Date last seen? _____
- () () Has any previous dental treatment occurred? If yes, what? _____
- () () Were there any problems with the previous dental treatment? If yes, what were they? _____
- () () Is your drinking water fluoridated?
- () () Are supplemental fluorides (e.g. rinse, gel, tabs) used? Please describe. _____

How often are teeth brushed? _____ Flossed? _____ By whom? _____

If there are any special concerns, please state in your own words. _____

How do you expect your child to react to his/her visit today? () excellent () good () fair () poor () not sure

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services the patient may need. I also authorize the dentist to release any information including diagnosis and the records of treatment or examination rendered to the patient during the period of such care to third-party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to Upstate Pediatric Dentistry, P.A. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to the patient. I also authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services.

Signature of Legal Consent

Date