Medical and Dental History

Patient's Name_ ____Date of birth__________ Age______ ☐ Male ☐ Female

MEDICAL HISTORY

Yes No
( ) ( ) Is patient in good health?
( ) ( ) Is patient under a physician's care for medical conditions?____
( ) ( ) Does patient have any history of major illness? ____
( ) ( ) 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? ______

Physician's name and contact phone number____

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

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

Any other significant medical, psychological, or disability problems? ____ Please describe.
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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/thumb or have a paci habit? 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 Guardian **Date**