BEARDEN FAMILY DENTISTRY

CHILD DENTAL / MEDICAL HISTORY

PERSONAL INFORMATION

Child's Name: _____ Child's Date of Birth: _____

DENTAL INFORMATION

What is the reason for your child's visit? ❒ Full Exam ❒ Emergency ❒ Consultation

Is your child in pain? ❒Yes ❒No If yes, for how long and in what area? _____

Child's Former Dentist_____City, State_____Last Dental visit date_____

Date of child's last Oral X-rays_____Do you help your child floss and how often?_____

How often do you help your child brush?_____Does your child require premedication? ❒Yes ❒No

Is your water at home fluoridated_____ What would you like to improve? _____

Check all that apply:

Bad Breath	❒Yes ❒No	Loose teeth or broken filling	❒Yes ❒No	Sensitivity to sweets	❒Yes ❒No
Bleeding gums	❒Yes ❒No	Orthodontic Treatment	❒Yes ❒No	Sensitivity when biting	❒Yes ❒No
Blisters on lip/mouth	❒Yes ❒No	Pain around ear	❒Yes ❒No	Frequent headaches	❒Yes ❒No
Fingernail biting	❒Yes ❒No	Tooth Pain	❒Yes ❒No	Jaw, head or neck injuries	❒Yes ❒No
Grinding teeth	❒Yes ❒No	Sensitivity to cold	❒Yes ❒No	Jaw clicking and/or pain	❒Yes ❒No
Lip and cheek biting	❒Yes ❒No	Sensitivity to heat	❒Yes ❒No		

MEDICAL INFORMATION

Physicians Name: _____ Date of Last Visit: _____

Are you currently under medical treatment? ❒Yes ❒No If yes, for what? _____

Has your child ever taken Ritalin? ❒Yes ❒No If yes, for how long? _____ What is the child's blood type? _____

Does your child do any of the following? ❒Thumb / Finger Sucking ❒Tongue Thrusting / Sucking ❒Heavy Snoring ❒Mouth Breathing ❒Lip Sucking / Biting

Have you had an allergic reaction to any of the following?

Local Anesthetics	❒Yes ❒No
Penicillin or other Antibiotics	❒Yes ❒No
Sulfa Drugs	❒Yes ❒No
Barbiturates and/or Sedatives	❒Yes ❒No
Sleep Apnea	❒Yes ❒No
Lodine	❒Yes ❒No
Aspirin	❒Yes ❒No
Latex	❒Yes ❒No

Is your child currently taking any medications? ❒Yes ❒No If yes, please list: _____

_____

Please list any other surgeries or medical conditions your child has ever had: _____

_____

MEDICAL INFORMATION - continued

Please mark any that apply:

AIDS	❒Yes	❒No	Diabetes	❒Yes	❒No	Nervous Problems	❒Yes	❒No
Anemia	❒Yes	❒No	Emphysema	❒Yes	❒No	Pacemaker	❒Yes	❒No
Arthritis	❒Yes	❒No	Epilepsy	❒Yes	❒No	Psychiatric care	❒Yes	❒No
Artificial Heart Valves	❒Yes	❒No	Fainting/Dizzy	❒Yes	❒No	Radiation	❒Yes	❒No
Artificial Joints	❒Yes	❒No	Glaucoma	❒Yes	❒No	Respiratory	❒Yes	❒No
Asthma	❒Yes	❒No	Headaches	❒Yes	❒No	Rheumatic Fever	❒Yes	❒No
Back Problems	❒Yes	❒No	Heart Murmur	❒Yes	❒No	Scarlet Fever	❒Yes	❒No
Bleeding abnormally,	❒Yes	❒No	Heart Problems	❒Yes	❒No	Shortness of breath	❒Yes	❒No
with surgery/extractions	❒Yes	❒No	Hepatitis	❒Yes	❒No	Sinus Trouble	❒Yes	❒No
Blood Disease	❒Yes	❒No	Herpes	❒Yes	❒No	Skin Rash	❒Yes	❒No
Cancer	❒Yes	❒No	High Blood Pressure	❒Yes	❒No	Stroke	❒Yes	❒No
Chemical Dependency	❒Yes	❒No	HIV Positive	❒Yes	❒No	Swelling of feet/ankles	❒Yes	❒No
Chemotherapy	❒Yes	❒No	Jaundice	❒Yes	❒No	Swollen Neck Glands	❒Yes	❒No
Chronic Fatigue Synd.	❒Yes	❒No	Jaw Pain	❒Yes	❒No	Thyroid Problems	❒Yes	❒No
Circulatory problems	❒Yes	❒No	Kidney Disease	❒Yes	❒No	Tonsillitis	❒Yes	❒No
Congenital Heart Issues	❒Yes	❒No	Liver Disease	❒Yes	❒No	Tuberculosis	❒Yes	❒No
Cortisone Treatment	❒Yes	❒No	Low Blood Pressure	❒Yes	❒No	Tumor/growth on head	❒Yes	❒No
Cough-persistent	❒Yes	❒No	Mitral Valve Prolapse	❒Yes	❒No	Ulcer	❒Yes	❒No
Taken Bisphosphonates	❒Yes	❒No	Venereal Disease	❒Yes	❒No	Human Papilloma Vaccine	❒Yes	❒No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and Parent/Guardian.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____