Patient Name: _____ Date: _____

Medical History

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no and explain below:

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Down Syndrome	☐	☐	Psychiatric problems	☐	☐
AIDS/HIV+	☐	☐	Eye problems	☐	☐	Rheumatic Fever	☐	☐
Allergies (seasonal)	☐	☐	Hearing loss	☐	☐	Sensory disorder	☐	☐
Asthma	☐	☐	Head trauma	☐	☐	Seizures	☐	☐
Autism	☐	☐	Heart problems	☐	☐	Shunts	☐	☐
Bleeding disorder	☐	☐	Hepatitis/Type____	☐	☐	Speech disorder	☐	☐
Cancer/Tumors	☐	☐	Mental disabilities	☐	☐	Spina Bifida	☐	☐
Cystic Fibrosis	☐	☐	Physical disabilities	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Pregnant	☐	☐			
Other	☐	☐	Please explain: _____					

	Yes	No
1. Is your child allergic to anything? (medications/food/food dyes/nuts) If yes, please list: _____	☐	☐
2. Is your child taking any medications/vitamins at this time? If yes, what? _____	☐	☐
3. Has your child ever been hospitalized? If yes, please explain (why, where, how long)? _____	☐	☐
4. Has your child ever had any surgeries (tubes, tonsils, etc.)? If yes, please explain: _____	☐	☐
5. Was your child full term? If not, what week of gestation were they born? _____	☐	☐
6. Did your child have any difficulty after birth/serious illnesses first year of life? If yes, please explain: _____	☐	☐
7. Is your child being treated by a physician at this time?	☐	☐

8. Name of child's physician: _____ Physician's phone #: (___) _____

Date of last visit: _____ Immunizations up to date? ☐ Yes ☐ No

9. Does your child have problems in: ☐ concentrating ☐ learning ☐cooperating ☐ understanding

10. How would you rate your child's attitude towards medical/dental visits?
☐ positive ☐ anxious ☐ definitely negative

11. Is there anything else we should know about your child? _____

_____

Patient Name: _____ Date: _____

Dental History

1. Is this your child's first dental visit? ☐ Yes ☐ No

2. Has your child ever had any of the following? Please check all that apply.

☐ abscesses ☐ toothaches ☐ cold sores ☐ ulcers

☐ bad breath ☐ injury to front teeth ☐ grinding

3. Does your child have any habits or a history of a habit?

Pacifier ☐ Yes ☐ No ☐ Age discontinued _____

Finger/thumb ☐ Yes ☐No ☐ Age discontinued _____

4. Is there a history of dental decay or missing teeth in the family?

☐ Yes ☐ No If yes, Explain: _____

5. Are your child's teeth brushed once or more a day by an adult? ☐ Yes ☐ No Floss? ☐ Yes ☐ No

6. What dental concerns do you have about your child? _____

_____

7. If your child is under the age of 6, when did their first baby tooth erupt? _____

8. Does your child snore? ☐ Yes ☐ No

9. Does your child mouth breathe? ☐ Yes ☐ No

Diet History

1. Did or Do you breast feed your child? ☐ Yes ☐ No
   What age did you discontinue breastfeeding? _____

2. Did or Do you bottle feed your child? ☐ Yes ☐ No
   What age did you discontinue bottle-feeding? _____

3. What foods does your child like for a snack? _____

4. What does your child drink on a daily basis? _____

5. Does your child take a vitamin? ☐ Yes ☐No
   If yes, what kind? _____

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in my child's medical status. I authorize Dr. Light and her dental staff permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper acceptable methods used in the specialty of pediatric dentistry (including diagnostic radiographs). I give Dr. Light and her staff permission to send record or x-rays to another facility/doctor in case of emergency. This consent shall remain in full force and effect until canceled by either party.

_____	_____	_____	_____
Signature of parent or guardian	Relationship to patient	Date	Dr. Initials