

Dental History Form

Patient's Name: _____ Date of Birth: _____

Address: _____

Is this the child's first dental appointment? _____ If not when was last appointment? _____

Has the child had any problem with dental treatment in the past? _____

Has the child ever suffered from any injuries to the mouth? _____

Has the child had any problems with the eruption or shedding of teeth? _____

Has the child had any orthodontic treatment? _____

Does your household tap water have Fluoride? _____

Does your child take Fluoride supplements? _____

Does your child use Fluoride toothpaste? _____

How many times a day is the child brushing and when? _____

Does the child use a pacifier or suck their thumb? _____

At what age did the child stop bottle feeding/Nursing? _____

Is there anything our staff can do to make your child more comfortable during their dental appointment? _____

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please print name of minor/child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent (s) is covered by insurance with _____ and assign directly to

Name of Insurance Company (ies)

Dr. Rana Mathias/Parkside Dentistry P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Signature of Parent, Guardian or personal representative

Date

Please print name of parent, Guardian or personal representative

Relationship to patient

Witness

Date

Medical History Form

Patient's Name: _____ Date of Birth: _____

	Y N DK		Y N DK		Y N DK
Abuse-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mumps-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
ADD/ADHD-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	OCD-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Anemia-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ear Aches-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ODD-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Anxiety-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating Disorders-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Obstructed Sleep Apnea-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Apthous Ulcers(canker sores) --	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy/Seizures-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	PDD-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arthritis-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pregnancy (teens)-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma: use of inhaler-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal Problems-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic Fever-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma triggers: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Growth Problems-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Seizures-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Autism-Spectrum: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heart Murmur-Innocent-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sickle Cell Disease/Trait-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Autism: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heart Murmur-SBE needed-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Snoring-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Autoimmune Disorders-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heart Valve Replacement-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Speech Delay-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bladder-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Endocarditis/Heart Infection--	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Spina bifida-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bed Wetting-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay Fever (seasonal allergies)-	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bleeding Disorders/Hemophilia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tobacco/Drug use-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Blood Transfusion-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tonsil/Adenoid Problems-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bones/Joints-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	HIV/AIDS-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Venereal Disease-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cancer-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hydrocephalus Shunt-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vision/Eye Problems-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cerebral Palsy-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Immunizations-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Syndrome: _____	
Chicken Pox-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Joint Replacements-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
Cleft Lip/Palate-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
Cold Sores-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex Allergy-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	OTHER: _____	
Congenital Heart Defect-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Liver-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
Cystic Fibrosis-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Measles-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
Developmental Delays-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mentally Challenged: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
Depression-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mononucleosis-----	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	

Are there any other **ILLNESSES** we need to be aware of? If yes please list them below:

Has your child ever had and **SURGERY** including, General Anesthesia, Conscious Sedation, or IV sedation?

Is your child taking any **PRESCRIPTION** and or over the counter **MEDICATIONS** or vitamin supplements at this time? If yes please list below:

Is your child **ALLERGIC** to any **MEDICATIONS** or certain **FOODS** i.e. penicillin, antibiotics, or other drugs? If yes please explain allergy below:

Has your child ever been **HOSPITALIZED** or to the **EMERGENCY** room? If yes please explain below:

Has your child **EVER** had **ANY HEART ISSUES** in the past? If yes please explain below:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Parents/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____