TOWN SQUARE DENTAL CARE

Today's Date:

Child's Dental and Medical Health History Form

To the parent/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

PATIENT'S DENTAL HEALTH HISTORY

What is your reason for your visit today?

Does the patient currently have any dental pain or discomfort? □Yes □ No If yes, where?
_____

Is this the patient's first visit to a dentist? □Yes □ No
If no, when was the patient's last dental exam? _____ What was done at that appointment?
_____

When was the last time the patient had dental x-rays taken?

Please check any box that applies to the patient :
Yes No ?

Has the patient had any problem with dental treatment in the past?
□ □ □
If yes, please describe what happened:

Has the patient had any problems with teeth coming in or losing teeth?
□ □ □

Does the patient use fluoride toothpaste when brushing teeth?
□ □ □
How often are the patient's teeth brushed? _____time(s) per _____ At what time(s) of day are the teeth brushed?
_____

Has the patient ever worn braces or other orthodontic appliances?
□ □ □

Has the patient ever had a serious injury to the head, mouth or teeth?
□ □ □
If yes, please describe what happened and when it happened:

Does the patient play any contact sport or participate in active recreational activities?
□ □ □
If yes, please describe those activities here:

What is the patient's primary source of drinking water? □Tap □Bottled □Filtered □Well

Are the patient's teeth sensitive to hot and cold?
□ □ □

Are the patient's teeth sensitive to biting or chewing? □ □ □
Do gums bleed or hurt when brushed? □ □ □
Does the patient bite their nails? □ □ □
Does the patient clinch or grind their teeth? □ □ □
Does the patient get sores/blisters in their mouth? □ □ □
Infants and Toddlers:
Does/did the patient use a pacifier or suck his/her thumb or fingers? □ □ □
At what age did the patient stop breastfeeding? At what age did the patient stop bottle feeding?
Does the patient take a bottle or sippy cup to bed? □ □ □
PATIENT'S MEDICAL HEALTH HISTORY
Please list the name and phone number of the patient's physician:
Doctor's Name: Phone:
Does the patient see any medical specialists? □ Yes □ No If yes, please explain:
Please check any box that applies to the patient: Yes No ?
Is the patient currently being treated for any condition(s) or illness(es) □ □ □
If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?..... □ □ □
If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized? ..... □ □ □
If yes, when and why?
Has the patient ever had blood transfusion? ..... □ □ □
Does that patient experience excessive bleeding when cut? ..... □ □ □
Has the physician or dentist ever suggested that the patient take antibiotics before seeing a dentist?..... □ □ □ If so, please provide the name of the doctor making the recommendation. Doctor's name: _____Phone:_____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions? ..... **Y N ?** □ □ □ If yes, please explain:
Does the patient have any genetic (inherited) condition?..... □ □ □ If yes, please explain: _____ Does the patient have any speech difficulties?..... □ □ □

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How would you describe the patient's eating habits?

PATIENT'S MEDICAL HEALTH HISTORY

Please check any box that applies to the patient:

□ ADD/ADHD	□ Chemotherapy	□ Heart murmur	□ Seizure
□ Alcohol/Drugs	□ Chicken Pox	□ Hepatitis	Last date of seizure: _____
□ Anemia	□ Chronic sinusitis	□ HIV/AIDS	□ Sexually transmitted infection
□ Anxiety	□ Cold Sores	□ Kidney problems	□ Sickle cell anemia
□ Arthritis	□ Depression	□ Liver problems	□ Thyroid issues
□ Asthma	□ Diabetes	□ Measles	□ Tobacco/vaping
Date of last attack: _____	Last known A1C: _____	□ Mononucleosis	□ Tuberculosis
Do you carry an inhaler? □Yes□No	Date of last A1C:_____	□ Mumps	□ Other: _____
□ Bladder problems	□ Ear aches	□ Pregnancy (teens)	_____
□ Bleeding disorders	□ Epilepsy	□ Radiation therapy	
□ Bone/Joint issues	□ Fainting	□ Rheumatic fever	
□ Cancer	□ Growth problems	□ Seasonal allergies	
□ Cerebral Palsy	□ Hearing problems		

MEDICATION & ALLERGIES

Please check the box that applies to the patient:
Yes No ?

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?..... □ □ □

If yes, please list them here:
_____

If the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?..... □ □ □

If yes, please list those medications and what happened when the patient took them:_____

Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc?..... □ □ □

If yes, please describe the allergies and the reactions:
_____

Do you carry an epi pen?..... □ □ □

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.
I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.
Signature of Parent/Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____
Office Use Only:
□ Medical Alert □ Premedication □ Allergies Anesthesia
Reviewed by:_____ Date: _____