Kidsworld Pediatric Dentistry

MEDICAL HISTORY **Welcome to Our Office!**

Child's Information

Name: _____ Nickname: _____ Birthdate: _____
Home Address: _____City/Prov: _____Postal Code: _____
Child lives with: (Please circle) Both Parents / Mother / Father / Guardian_____ Home Tel: _____
Child's School: _____ Grade: _____ Child's Age: _____

Parent/Guardian Information

Mother/Guardian's Name: _____ Birth date: _____
Mother/Guardian's Address (if different from above): _____
Home Tel: _____ Cell Phone: _____ Email: _____
Mother/Guardian Employed by: _____ Occupation: _____
Mother/Guardian's Dental Insurance: _____ Group #_____ID#_____
Who is responsible for this account? (Which parent/guardian):_____

Father/Guardian's Name: _____ Birth date: _____
Father/Guardian's Address (if different from above): _____
Home Tel: _____ Cell Phone: _____ Email: _____
Father/Guardian Employed by: _____ Occupation: _____
Father/Guardian's Dental Insurance: _____ Group #_____ID#_____

Names / Ages of other children in family?_____
Do other children in the family have a history of decay? _____
Whom may we Thank for referring your child? _____
Do you desire **ROUTINE DENTAL CARE** for your child? ☐Yes ☐No

Medical History

Primary Physician's Name: _____ Phone: _____
Address: _____
Does your child receive **Regular** medical "well checks"? ☐Yes ☐No
Date of Last Med. Exam: _____Reason for Last Med. Exam: _____
Are immunizations current? ☐Yes ☐No If not, please note reason:_____
Was birth full-term or premature (number of weeks)? _____
Has Mother or child had a history of illness at birth or after? (ex. Frequent infant ear infections, complicated delivery, frequent use of antibiotics, etc.) _____
Are you the biological parent? ☐Yes ☐No If NO, explain _____

Please circle Y or N if your child is, or has been, affected by any of the following conditions:

Physical Disability	Y	N	Previous Hospital Admission(S)	Y	N
Seizures/Epilepsy	Y	N	Asthma	Y	N
Tuberculosis	Y	N	Rheumatic Fever	Y	N
HIV/AIDS	Y	N	Congenital Heart Defect/Heart Conditions	Y	N
Diabetes	Y	N	Congenital Birth Defect	Y	N
Hepatitis	Y	N	Abnormal Blood Pressure	Y	N
Cancer	Y	N	Bleeding Disorder	Y	N
Kidney/Liver Problems	Y	N	Hearing Impairment	Y	N
Psychiatric Therapy	Y	N	Learning Disability	Y	N
ADD/ADHD	Y	N	Autism	Y	N

Please indicate **allergies** or **reactions** to medications/latex/other: _____
Please list name and amount of **ANY** prescription medications/vitamins/supplements taken:
_____
Any other current illnesses or conditions/concerns not listed above:
_____

Please complete reverse side

Kidsworld Pediatric Dentistry

Dental History

Is this your child's first visit to a Pediatric Dental Office? ☐Yes ☐No
If NO, please indicate previous name and location: _____
Please describe previous dental experience (if any):_____
How did your child react at previous office? _____
What was your (parent/guardian) reaction at previous office? _____
Name of previous dentist: _____ Date of last visit: _____ Date of last xrays: _____
At what age/month did your child's first tooth arrive? _____

Does your child brush daily?	☐Y	☐N	How Often (times per day) _____
Do you assist your child in brushing?	☐Y	☐N	How Often_____
Do you floss your child's teeth?	☐Y	☐N	How Often_____
Does your child take fluoride or vitamin supplement?	☐Y	☐N	How Often_____
Does your child have any mouth habits? (thumb sucking, pacifier use, nail biting, chewing pencils, etc.)	☐Y	☐N	Describe_____
Does your child take a bottle or sippy cup to bed?	☐Y	☐N	If yes, what contents? _____
Does your child have a history of Cold sores or fever blisters?	☐Y	☐N	Describe _____
Has your child complained or shown symptoms of dental problems (pain, fingers in mouth, etc.)?	☐Y	☐N	How recently_____ Describe _____

Main dental concerns: _____

Has your child **had any** bad dental experiences? ☐Y ☐N Describe_____

Has your child **had any** injuries to the mouth or head? ☐Y ☐N Describe_____

Dietary History

Does your child snack frequently?	☐Y	☐N	On what? _____
Does your child drink juice frequently?	☐Y	☐N	What kind? _____

Note: Many fruit juices have natural acids which can cause cavities if taken frequently

Does/did your child take a bottle to bed?	☐Y	☐N	Explain: _____
Is your home water supply fluoridated?	☐Y	☐N	
Does your child take a fluoride supplement?	☐Y	☐N	

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes to my child's medical status.

I authorize the staff of Kidsworld Pediatric Dentistry to perform any required dental services for my child and hereby give my parental permission to take any necessary radiographs.

Parent / Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____