MEDICAL HISTORY FORM

Child's Full Name: ______________________________ DOB: ________________ Todays Date: _______

□ Male □ Female Weight: ________________

Child's Pediatrician: ________________________ Phone #: _____________________________________

Specialty Doctor Name/Phone#: ____

Is your child currently being treated by a physician? o Yes o No If yes, Reason: _____________________

Is your child currently taking any medications (prescription or over the counter)? o Yes o No

Please list **medications**/dose/frequency/date started____

Any **allergies** to medications, latex, etc.? o Yes o No Please list: ________________________________

Any hospitalizations/surgeries/emergency room visits? List date and describe? ________________________

Does your child have now or has had any of the following?

Yes/No Describe

Yes	No	Condition	Describe
		Asthma/breathing problems	Last attack date:
		ADD/ADHD	
		Autism	
		Blood Disorders/bruise easily/hemophilia/anemia	
		Cancer/tumors	
		Congenital heart defects/heart murmur	
		Diabetes	Last A1C percentage:
		Ear /sinus Infections	
		HIV/sexually transmitted disease	
		Hydrocephaly/shunt placement	
		Kidney disease/bladder problems	
		Liver disease/jaundice/hepatitis	
		Muscle/bone/joint	
		Premature birth /Complications during pregnancy	
		Stomach/intestinal problems/GERD	
		Special needs/development delay/syndrome	
		Seizures/brain injury	Last seizure date:
		Thyroid	
		Tonsils/snoring	
		Tuberculosis/ MRSA	
		Vision/hearing/speech	
		Any other significant medical history?	Please list:

DENTAL HISTORY FORM

What is the reason for your visit today?

o Checkup o Tooth Ache o Cavities o Injury o Consultation/Second Opinion

Has your child ever been to a dentist? o Yes o No Previous dentist's name: ______________________________

Any negative dental experiences? o Yes o No Explain: ____

If your child needs dental work, how do you anticipate their behavior to be?

o Cooperative o Shy o Nervous o Uncooperative

YES	NO	
		Are you aware of any cavities now?
		Do other people in the family have cavities?
		Does your child floss?
		Does someone help child brush teeth?
		Is your child breast or bottle feeding at night?

YES	NO	
		Does your child drink Juice/soda/sports drinks regularly? (circle)
		Does your child take children's vitamins?
		Mouth sores or blisters?
		Bleeding gums?
		Sensitive teeth?
		Cleft lip/palate
		History of injury to teeth?

CONSENT

I am the parent or guardian of __________________________ (child's name) and there are no court orders now in effect that prohibit me from signing this consent. I acknowledge that the above information is correct and grant the Doctor and Staff of Sorenson Pediatric Dentistry permission to provide my child with dental and related medical/surgical treatment, utilizing proper and acceptable methods used in the specialty of pediatric dentistry, including, but not limited to radiographs (x-rays) and administration of local anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

______________________	______________________	__________	____
Printed Name of Parent or Guardian	Signature of Parent of Guardian	Relationship	Date