Pediatric Dentistry Of Reading

Patient Health History Form New Printable

Patient Name: Birth Date: Date Created:

Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forwa

Patient Information

Father's Name ______________________ Mother's Name ______________________

Guardian's Name ______________________

Name Child Prefers to be Called ______________________

Emergency Contact Information

In the event of an emergency, whom should we contact?

Name ______________________ Relationship ____________ Phone ____________

Name ______________________ Relationship ____________ Phone ____________

Dental History

How did you hear about us? ______________________

Name of previous dental office and date of last visit? ______________________

Reason ______________________

Chief dental concern today? ______________________

Has child complained about dental problems? ◯ Yes ◯ No If yes

Does child brush teeth daily? ◯ Yes ◯ No

Does Child use floss daily? ◯ Yes ◯ No

Is child taking fluoride in any form? ◯ Yes ◯ No If yes

Has child had any injuries to mouth and/or teeth? ◯ Yes ◯ No If yes

Has child ever had any unhappy dental experiences? ◯ Yes ◯ No If yes

Does child have any of the following habits?

Sucks thumb ◯ Yes ◯ No

Nail biting ◯ Yes ◯ No

Mouth breathing/Snores ◯ Yes ◯ No

Pacifier ◯ Yes ◯ No

Goes to bed/sleeps with bottle ◯ Yes ◯ No

Breast/Bottle Feeding ◯ Yes ◯ No

Medical History

Child's Physician ______________________

City/State ______________________ Phone ______________________

Last Physical Exam ______________________ Results ______________________

Is child under care of physician now? ◯ Yes ◯ No If yes

Has child ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes

Is child taking any medications, pills, drugs or vitamins? ◯ Yes ◯ No If yes

Does child have excessive bleeding when cut? ◯ Yes ◯ No If yes

Has child ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Is child on a special diet? ◯ Yes ◯ No If yes

Does child use tobacco or controlled substances? ◯ Yes ◯ No If yes

Female Patients Only

Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Allergies

Are you allergic to any of the following?

Penicillin/Amoxicillin	◯ Yes ◯ No
Latex	◯ Yes ◯ No
Red Dye	◯ Yes ◯ No
Gluten	◯ Yes ◯ No
Nuts	◯ Yes ◯ No
Peanuts	◯ Yes ◯ No

Other ______________________ ◯ Yes ◯ No

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

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
ADHD	◯ Yes ◯ No	Autism (ASD)	◯ Yes ◯ No				

Has your child ever had any serious illness not listed above?______________ ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________