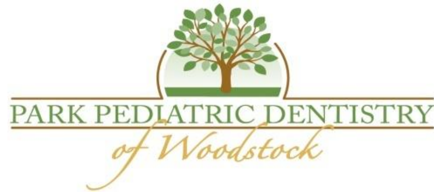


Patient Information

Today's Date ________/________/________

Patient: LAST FIRST INITIAL	Nickname	Date of Birth / /
Address STREET CITY STATE ZIP CODE		
Phone HOME	CHILD'S SOC SEC #	Sex: M ☐ F ☐
SCHOOL	GRADE	HOBBIES
Child primarily lives with	Person financially responsible	
How did you hear about our practice?		

Father: ☐ Stepfather ☐ Guardian Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ LAST FIRST INITIAL	E-Mail	
Address (If Different from Above) STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		
Employer	Date of Birth / /	Driver's License #

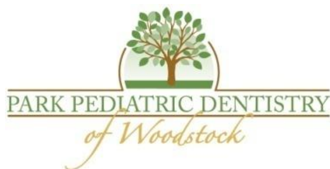
Mother: ☐ Stepmother ☐ Guardian Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ LAST FIRST INITIAL	E-Mail	
Address (If Different from Above) STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		
Employer	Date of Birth / /	Driver's License #

Who should we contact regarding your child's appointment?

How would you prefer to be contacted? ☐ via E-Mail ☐ via Text ☐ via Home Phone ☐ via Cell Phone

Insurance Information: Policy Holder	SS#	Date of Birth / /
Employer	Relationship to Patient	
Insurance Company	Group Number	Policy Number
Mailing Address	Phone Number	

Emergency Contact: LAST FIRST	Relationship to Patient
Address STREET CITY STATE ZIP CODE	
Phone HOME CELL WORK EXT	



Medical History

Patient: LAST	FIRST	INITIAL	NICKNAME	Age
Medical Information Child's Pediatrician				Phone Number

Date of Last Physical: / /	Are your child's immunizations up to date? ☐ YES ☐ NO	Current Physical Health: ☐ Excellent ☐ Fair ☐ Poor

Is child currently under the care of a physician? ☐ YES ☐ NO
If yes, explain:

Has your child ever been hospitalized, sedated or had surgery? ☐ YES ☐ NO
If yes, explain:

Has your child ever had a serious head or neck injury? ☐ YES ☐ NO
If yes, explain:

Is your child taking any medications? ☐ YES ☐ NO
List:

Is your child on a special diet? ☐ YES ☐ NO
Type:

Does your child have any allergies to medicines, latex, food or metals? ☐ YES ☐ NO
List:

Are antibiotics necessary for dental work due to a heart murmur, heart defect, prosthesis, shunt or any other reason? ☐ YES ☐ NO
If yes, explain:

Has any member of the family, including your child, had a problem with sedation or general anesthesia? ☐ YES ☐ NO
If yes, explain:

Does your child have any handicaps or disabilities? ☐ YES ☐ NO
If yes, explain:

Medical History

Please check "Y" for Yes or "N" for No if your child has had any history of, or conditions relating to, any of the following:

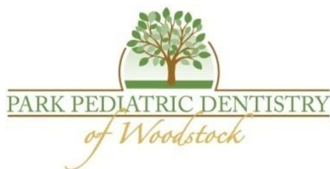
☐ Y ☐ N Abnormal Bleeding	☐ Y ☐ N Cleft Palate/Lip	☐ Y ☐ N Growth Problems/Delays	☐ Y ☐ N Lung Disease
☐ Y ☐ N ADD/ADHD	☐ Y ☐ N Cold Sores/Fever Blisters	☐ Y ☐ N Hayfever/Allergies	☐ Y ☐ N Measles
☐ Y ☐ N AIDS/HIV+	☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Hearing Impairment	☐ Y ☐ N Mononucleosis
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Convulsions	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Mumps
☐ Y ☐ N Anemia	☐ Y ☐ N Cortisone Medicine	If yes, is Heart Murmur innocent?	☐ Y ☐ N Pain in Jaw Joints
☐ Y ☐ N Asthma	☐ Y ☐ N Diabetes	☐ Yes ☐ No	☐ Y ☐ N Pregnancy
☐ Y ☐ N Autism	☐ Y ☐ N Down Syndrome	☐ Y ☐ N Heart Trouble/Disease	☐ Y ☐ N Premature Birth
☐ Y ☐ N Behavioral Problems	☐ Y ☐ N Drug/Alcohol Abuse	☐ Y ☐ N Hemophilia	☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Birth Defects	☐ Y ☐ N Earaches/Ear Infections	☐ Y ☐ N Hepatitis	☐ Y ☐ N Recent Weight Loss
☐ Y ☐ N Bladder Problems	☐ Y ☐ N Easily Winded	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Blood Disease	☐ Y ☐ N Eating Disorder	☐ Y ☐ N Hives/Rash	☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Blood Transfusions	☐ Y ☐ N Epilepsy/Seizures	☐ Y ☐ N Hypoglycemia	☐ Y ☐ N Sickle Cell Disease
☐ Y ☐ N Brain Injury	☐ Y ☐ N Excessive Bleeding	☐ Y ☐ N Irregular Heart Beat	☐ Y ☐ N Sinus Problems
☐ Y ☐ N Breathing Problem	☐ Y ☐ N Excessive Thirst	☐ Y ☐ N Kidney Problems	☐ Y ☐ N Speech Impairment
☐ Y ☐ N Bruise Easily	☐ Y ☐ N Fainting/Dizziness	☐ Y ☐ N Learning Disabilities	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Cancer/Tumor	☐ Y ☐ N Frequent Cough	☐ Y ☐ N Leukemia	☐ Y ☐ N Stomach Problems
☐ Y ☐ N Cerebral Palsy	☐ Y ☐ N Frequent Diarrhea	☐ Y ☐ N Liver Disease	☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Chicken Pox	☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Tuberculosis

Is there any other health information that should be known? ☐ YES ☐ NO

If yes, explain:

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information is dangerous to my child's health. It is my responsibility to inform Park Pediatric Dentistry of any changes to my child's medical status.

Signature of Parent/Guardian ____ Date _____________________



Dental History

Patient:

LAST FIRST INITIAL NICKNAME

Age

Dental History

Previous Dentist

Phone Number

Date of Last Dental Visit: / /	Date of Last Cleaning: / /	Date of Last X-Rays: / /

Do you have a copy of your child's previous x-rays? ☐ YES ☐ NO

Has your child been to an orthodontist for an evaluation? ☐ YES ☐ NO

Is your child currently seeing an orthodontist? ☐ YES ☐ NO

Orthodontist Name

Phone Number

Does your child have a history of unfavorable reactions to the dentist? ☐ YES ☐ NO

If yes, explain:

My child brushes ___________ times per day.	My child flosses every day: ☐ YES ☐ NO
Is tooth brushing supervised? ☐ YES ☐ NO	Is fluoride taken in any form? ☐ YES ☐ NO

Has there been any previous injuries to your child's mouth, teeth or jaw? ☐ YES ☐ NO

If yes, explain:

Does your child:

☐ Use a Pacifier	☐ Chew/Bite Nails	☐ Clench their Jaw
☐ Suck Thumb/Fingers	☐ Chew Hard Objects	☐ Breath through Mouth
☐ Sleep with a Bottle/Sippy Cup	☐ Grind Teeth	☐ Snore

For children under 5, was/is your child being: ☐ Breast-Fed ☐ Bottle-Fed

Today's Visit

Reason for today's visit:

Is your child experiencing any dental pain? ☐ YES ☐ NO

If yes, explain:

Does your child have a specific dental problem that needs attention? ☐ YES ☐ NO

If yes, explain:

Pharmacy

Pharmacy Name Location

Phone Number

Consent for Treatment

To the best of my knowledge, the information given herein is accurate and complete. It is my responsibility to inform Park Pediatric Dentistry of Woodstock of any changes in my child's medical or dental status.

I am the parent or legal guardian of _______________________________________ and there are no court orders in

Please Print Name of Minor/Child

effect that prohibit me from signing this consent. I do hereby request and authorize Dr. Park and/or his staff to perform necessary dental procedures for the child named above, including but not limited to, x-rays, the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

All procedures will be discussed with you prior to any dental treatment.

Signature of Parent or Legal Guardian Date

Please Print Name of Parent or Legal Guardian Relationship to Patient