

Why did you bring the child to the dentist today? _____

Has the child ever had a serious/difficult problem associated with previous dental work? _____

Is the child's water fluoridated? _____

Is the child taking fluoride supplements? _____

Has the child ever had any pain/ tenderness in his/ her jaw joint (TMJ/ TMD)? _____

Does the child brush his/her teeth daily? _____

Floss his/her teeth daily? _____

Has your child ever taken Fosamax, or any other bisphosphonate? _____

Has your child ever taken Phen-Fen? _____

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that the child is allergic to: _____

Does/did the child have any of the following habits?

___ Lip Sucking/Biting

___ Nail Biting

___ Nursing Bottle Habits

___ Thumb/Finger Sucking

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Has the child ever had any of the following medical problems?

___ Abnormal Bleeding

___ ADD/ADHD

___ Allergies to any drugs

___ Any Hospital Stays

___ Any Operations

___ Artificial Bones/Joints/Valves

___ Asthma

___ Cancer

___ Congenital Heart Defect

___ Convulsions/Epilepsy

___ Diabetes

___ Handicaps/Disabilities

___ Hearing Impairment

___ Heart Murmur

___ Hemophilia

___ Hepatitis

___ HIV+/AIDS

___ Kidney/Liver Problems

___ Rheumatic/Scarlet Fever

___ Sickle Cell Disease/Traits

___ Tuberculosis (TB)

Please discuss any serious medical problems that the child has had: _____

Neighbor or Relative not living with you.

Name: _____ Phone: _____

Address: _____

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

Signature

Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials: _____ Date: _____

Doctors Comments: _____

Medical History Update

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____