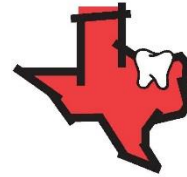


Office Use Only

Chart # _____

Health Alerts Yes No



PEDIATRIC DENTISTRY
Of North Texas

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____ Nickname: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ SS#: _____ - _____ - _____ Age: _____ Sex: Male Female (Circle)

Mother/Legal Guardian: _____ Relation to Patient: _____

Employer: _____ Work #: _____ Cell: _____

Email: _____ Date of Birth: _____ SS#: _____ - _____ - _____

Father/Legal Guardian: _____ Relation to Patient: _____

Employer: _____ Work #: _____ Cell: _____

Email: _____ Date of Birth: _____ SS#: _____ - _____ - _____

Person responsible for the account: _____

What other children in your family have we seen? _____

Who referred you to our office? _____

MEDICAL HISTORY

Child's Physician/Pediatrician: _____ Phone: _____

Yes No Is your child in good health? Date of last physical exam _____

Yes No Has your child ever had a health problem? _____

Yes No Is your child allergic to anything? If yes, what? _____

Yes No Are your child's immunizations/vaccines up to date? If not, please explain: _____

Yes No Has your child had any surgeries/hospitalizations? If yes, explain _____

Yes No Is your child currently taking any medications? Please give medications, dose, and reason: _____

Please check if your child has been treated for any of the following:

- | | | | | |
|---------------------------------------------------|------------------------------------------|---------------------------------------------|-------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma/breathing | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Blood dyscrasias | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Cleft lip/palate | |
| <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine/growth | <input type="checkbox"/> Eyesight | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver/GI Disease | <input type="checkbox"/> Mental delays | <input type="checkbox"/> Personality/social |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shunt |
| <input type="checkbox"/> Sick Cell Disease | <input type="checkbox"/> Snoring | <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Syndrome _____ |
| <input type="checkbox"/> Tonsil/adenoid | <input type="checkbox"/> Tuberculous | <input type="checkbox"/> Other _____ | | |

Has any member of your child's family had any of the above? If yes, please explain _____

DENTAL HISTORY

What is the reason for your child's dental visit?

Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____ Yes No

Name of previous dentist _____ Phone _____

Has your child had an unfavorable dental experience? Yes No

Has your child had a local anesthetic? Yes No

Has your child been sedated for dental treatment? Yes No

Have your child's teeth ever been injured? Yes No

Has your child had treatment for dental trauma? Yes No

Does your child suck a finger, thumb or pacifier or have any other oral habits? Yes No

Does your child go to bed with a bottle or sippy cup? Yes No

Any family history of tooth/gum problems or missing/extra teeth? Please explain _____ Yes No

Please check if you are concerned that your child has any of the following:

Cavities Toothache Sensitive Teeth Mouth Breathing Trauma Gum Infection

Color of teeth Orthodontics Jaw Sounds Grinding of Teeth

Other _____

Comments: _____

FLUORIDE HISTORY

Does your child drink tap water? Yes No

Does your child use fluoride toothpaste? Yes No

Do you give your child any other forms of fluoride? If yes, what? _____ Yes No

LEGAL CONSENT FORM

I give my permission for the following individuals to bring my child to the dentist

1) Name _____ Relationship _____ Phone _____

2) Name _____ Relationship _____ Phone _____

3) Name _____ Relationship _____ Phone _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information listed on both sides of this form is complete and accurate. I give consent for Dr. Robert E Morgan, associate dentists and dental staff to perform a dental exam, dental prophylaxis, fluoride treatment, and take x-rays on my child. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational, or research purposes.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform *Pediatric Dentistry of North Texas* of any changes in my child's medical status.

Parent/Legal Guardian's signature: _____ Date: _____

Doctor's Notes: _____