

Pediatric Dentistry of Greenwood

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CHILD'S MEDICAL AND DENTAL HISTORY (PLEASE PRINT CLEARLY)

Child's full name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Father's name: \_\_\_\_\_ Home Phone:( \_\_\_\_\_ ) \_\_\_\_\_

Father's Occupation/employer: \_\_\_\_\_ Work phone:( \_\_\_\_\_ ) \_\_\_\_\_

Mother's name: \_\_\_\_\_ Home Phone:( \_\_\_\_\_ ) \_\_\_\_\_

Mother's occupation/employer: \_\_\_\_\_ Work phone:( \_\_\_\_\_ ) \_\_\_\_\_

Who may we thank for referring our office \_\_\_\_\_

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH YOUR CHILD PRESENTLY HAS OR PREVIOUSLY HAD

- Aids
- Anemia
- Asthma
- Bleeding tendency
- Blood disease
- Blood transfusion
- Bone Disorder
- Brain Cancer
- Cancer
- Convulsions
- Diabetes
- Ear disorders
- Epilepsy
- Eye disorders
- Fainting
- Heart condition
- Hemophilia
- High blood pressure
- HIV-positive
- Hormone disorder
- Hyperactivity
- Jaundice
- Kidney disease
- Liver disease
- Lung disease
- Mental retardation
- Muscle disorder
- Nose/throat disorder
- Prolonged illness
- Rheumatic fever
- Skin disease
- Speech problem
- Stomach problem
- Other \_\_\_\_\_

Child's Physician (Name) \_\_\_\_\_ (Phone number) \_\_\_\_\_

- No  Yes Does your child have any other medical condition?
- No  Yes Is your child taking any medication?
- No  Yes Is your child allergic to any food or medicine?
- No  Yes Has your child ever been hospitalized?
- No  Yes Is this your child's first visit to a dentist?
- No  Yes Were there any problems with previous dental treatment?
- No  Yes Is your child using fluoride tablets, drops, or rinses?
- No  Yes Has your child had a toothache recently?
- No  Yes Does your child suck a thumb, finger or have any other oral habit?
- No  Yes Has your child ever injured his/her teeth or jaws?
- No  Yes Does your child have a dental condition about which you are especially concerned?

How often are your child's teeth brushed? \_\_\_\_\_ By whom? \_\_\_\_\_

What is the source of your child's drinking water?  Public water  Well water

I acknowledge that this information is correct and hereby authorize a dental examination for my child including necessary radiographs, photographs, and acceptable methods to accomplish these services. I authorize the use of any radiographs, photographs and records for the purpose of teaching, research and scientific publication. If there is a change with my child's health history, I will notify this office.

Parent or Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_