PATIENT NAME: _____

Child's nickname: _____ Sex: _____ Birthdate: _____ Age: _____

Does child live with both parents? ☐Yes ☐ No ☐ Mother? ☐ Father? ☐ Guardian?

Child's address: _____ Soc.Sec.# _____

INSURANCE ID # _____ ☐ Healthcare USA ☐ Missouri Care ☐ Molina ☐ Other _____

Father (or male guardian) complete name: _____
Home address (if different from child's) _____ Home phone: _____
☐ Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other _____ Soc.Sec.#: _____
Employed by: _____ City: _____ State: _____ Zip: _____
Cell #: _____ Work phone: _____
Dental insurance company: _____ Group number: _____
If student, where? _____

Mother (or female guardian) complete name: _____
Home address (if different from child's) _____ Home phone: _____
☐ Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other _____ Soc.Sec.#.: _____
Employed by: _____ City: _____ State: _____ Zip: _____
Cell #: _____ Work phone: _____
Emergency Contact Person _____ Phone _____ Cell _____

DENTAL HISTORY Is this your child's first visit to the dentist? ☐ Yes ☐ No
Is your child having any specific problems? ☐ Yes ☐ No Describe: _____
Last dental visit: _____ Purpose: _____ Last complete exam: _____
Has your child experienced an unfavorable reaction from previous dental or medical care? ☐ Yes ☐ No Specify _____
_____
How do you describe your child's dental health? ☐ Good ☐ Fair ☐ Poor
Has your child been seen here before? ☐ Yes ☐ No When_____
Do you feel your child may need Nitrous Oxide Sedation? ☐ Yes ☐ No ***or*** IV Sedation? ☐ Yes ☐ No
Has your child ever been under General Anesthesia? ☐ Yes ☐ No If yes, please explain _____
Does your child currently have a heart murmur? ☐ Yes ☐ No _____

MEDICAL HISTORY (Confidential. Repeated every five years.) Pediatrician/doctor's name: _____
Phys. Address: _____ Phys. Phone: _____ Last physical exam: _____
Does your child have any medical problems? ☐ Yes ☐ No Describe: _____
Is your child under a doctor's care now? ☐ Yes ☐ No If so, for what reason? _____
Is your child taking any medications, pills or drugs? ☐ Yes ☐ No Please list: _____
_____

Has your child ever had any of the following? Indicate YES with check mark (√)

❑ ADD	❑ Cancer	❑ Heart murmur *(in the past year)*	❑ Multiple Sclerosis	❑ Thyroid disease
❑ ADHD	❑ Cerebral Palsy	❑ Hemophelia	❑ OCD	❑ Tonsillitis
❑ Aids/HIV Positive	❑ Chicken pox	❑ Hepatitis A	❑ Other allergies	❑ Tuberculosis
❑ Allergy to anesthetics	❑ Diabetes	❑ Hepatitis B and C	❑ Prolonged bleeding	❑ Other *(please explain below)*
❑ Allergy to foods	❑ Down Syndrome	❑ Herpes	❑ Prosthetic valves / joints	
❑ Allergy to medicine/drugs	❑ Drug Addiction	❑ Jaundice	❑ Psychiatric treatment	
❑ Arthritis	❑ Epilepsy	❑ Kidney disease or dialysis	❑ Rheumatic fever	
❑ Asthma	❑ Fainting spells	❑ Malignancies	❑ Seizures or convulsions	
❑ Autism	❑ Heart disease	❑ Measles	❑ Sickle Cell	

Has your child ever been hospitalized? ☐ Yes ☐ No If Yes, When (Dates)? _____
List all of your child's allergies here: _____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent or Guardian Signature X _____ Date: _____

Reviewed by Doctor X _____ Date: _____

FOR OFFICE USE ONLY
B / P _____

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS
I have read my child's MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	Child's Age	EXCEPTIONS	PARENT/GUARDIAN SIGNATURE	REVIEWED BY
_____	_____	None ☐ _____	DR. _____	
_____	_____	None ☐ _____	DR. _____	
_____	_____	None ☐ _____	DR. _____	
_____	_____	None ☐ _____	DR. _____	