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Childrens & Adolescent Dentistry, Ltd Practice Limited To Pediatric Dentistry Diplomates American Board of Pediatric Dentistry

Dental And Medical Health Questionnaire

Date of Birth:	Rame (Parents): Occupation: Business Address: City: Phone: Referred by: Address (or City) Reason for dental visit s this your child's first dental experience? If not, when was last dental visit? Health Problems or Medications that you are taking could have an important interrelationship with the dentistry you re Thank you for completely filling out this form: Physicians name: Address (or City) s your child under a physician's care at this time? Why? s your child ever been hospitalized? Why? Please place an "X" to indicate if your child has a history of any of the following: Aldergies Covid 19 Kidney Problems Psychiatric Problem Antenia COVid 19 Kidney Problems Psychiatric Problem Arthritis Diabetes Learning Disabilities Reheumatic Fever Bleod Transfusion Endocrine Disorder Malignancies Social Problems Bleading Problems Endocrine Disorder Malignancies Social Problems Bleod Transfusion Halitosis (Bad Breath) Metabolism Problems Tonsillitis Sone) Corrollent Problems Tonsillitis Sone(Orthopedic) Problem Heart Problems Anxiety Disorders Visual Impairment Bleathing Problems Heart Problems Tonsillitis Sone(Orthopedic) Problem Heart Problems Anxiety Disorders Visual Impairment Social Problems Tonsillitis Sone(Orthopedic) Problem Heart Problems Anxiety Disorders Visual Impairment Sone(Orthopedic) Problem Heart Problems Social Problems Tonsillitis Tonsillitis Sone(Orthopedic) Problem Heart Problems Social Problems Tonsillitis Tonsillitis Sone(Orthopedic) Problem Heart Problems Social Problems Tonsillitis Sone(Orthopedic) Problem Social Problems Tonsillitis Sone(Orthopedic) Problem Social Problems Social Problems Tonsillitis Sone(Orthopedic) Problem Social Problems Social Problems Tonsillitis Sone(Orthopedic) Problem Social Problems Social P	Name(Child):	Nickname:	Phone:	Cell	Phone
Names and Ages of Brothers/Sisters Occupation:	Same (Parents): Same (Parents)	Address:	City:		Zip Code:	
City:	tame (Parents): taminess Address: City: Phone: Address (or City) Reason for dental visit: Striss your child's first dental experience? If not, when was last dental visit? How often does your child brush his/her teeth? Floss? Mouth Rinses? Health Problems or Medications that you are taking could have an important interrelationship with the dentistry you re Thank you for completely filling out this form: Address (or City) Address (or City) Address (or City) Address (or City) As your child under a physician's care at this time? Why? As your child presently taking any medication? What? Has your child ever been hospitalized? Why? Please place an "X" to indicate if your child has a history of any of the following: Address (or City) What? Please place an "X" to indicate if your child has a history of any of the following: Altergies Circulatory Problem Arthritis Diabetes Learning Disabilities Reheumatic Fever Asthma Ear (Hearing) Problems Behavior Disorder Seizure Disorder Beleding Problems Endocrine Disorder Malignancies Social Problems Bene(Orthopedio) Problem Heart Problems Bene(Orthopedio) Problem Heart Problems Bene(Orthopedio) Problems Heart Problems Heart Problems Cerebral Palsy H.I.V. Nutritional Problems	Date of Birth:	Height:	Weight:	EMAIL:	
teferred by:	teferred by:	Gender:Names	and Ages of Brothers/Sisters			
Address (or City) Reason for dental visit Season for dental visit If not, when was last dental visit? Season for dental visit Season for dental visit If yes, does your child ver an athletic mouthguard? Season for dental visit Season for dental visit Season for dental visit If yes, does your child wear an athletic mouthguard? Season for dental visit Season f	teferred by:	Name (Parents):		Occupation:		
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low often does your child brush his/her teeth?	low often does your child brush his/her teeth? Floss? Mouth Rinses? Health Problems or Medications that you are taking could have an important interrelationship with the dentistry you re Thank you for completely filling out this form: Address (or City)					
Does your child participate in organized athletics?	If yes, does your child participate in organized athletics? If yes, does your child wear an athletic mouthquard?					
Health Problems or Medications that you are taking could have an important interrelationship with the dentistry you Thank you for completely filling out this form: Address (or City) s your child under a physician's care at this time? What? It as your child ever been hospitalized? Why? See your child allergic to any medications? What? What? It case place an "X" to indicate if your child has a history of any of the following: Allergies Anemia COVid 19 Kidney Problems Circulatory Problems Covid 19 Kidney Problems Covid 19 Cov	Health Problems or Medications that you are taking could have an important interrelationship with the dentistry you re Thank you for completely filling out this form: hysicians name:					
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Allergies Circulatory Problem Intestinal Problems Oral Habits Anemia COVid 19 Kidney Problems Psychiatric Problems Arthritis Diabetes Learning Disabilities Rheumatic Feve Asthma Ear (Hearing) Problems Liver Problems Down Syndrome Behavior Disorder Seizure Disorder Malignancies Social Problems Bleeding Problems Endocrine Disorder Intellectual Disability Speech Problems Blood Transfusion Halitosis (Bad Breath) Metabolism Problems Tonsillitis Bone(Orthopedic) Problem Heart Problems Anxiety Disorders Visual Impairme Breathing Problems Hepatitis Neurologic Problems	Allergies Circulatory Problem Intestinal Problems Oral Habits Anemia COVid 19 Kidney Problems Psychiatric Problem Arthritis Diabetes Learning Disabilities Rheumatic Fever Asthma Ear (Hearing) Problems Liver Problems Down Syndrome Behavior Disorder Seizure Disorder Malignancies Social Problems Bleeding Problems Endocrine Disorder Intellectual Disability Speech Problems Blood Transfusion Halitosis (Bad Breath) Metabolism Problems Tonsillitis Bone(Orthopedic) Problem Heart Problems Anxiety Disorders Visual Impairment Breathing Problems Hepatitis Neurologic Problems Cerebral Palsy H.I.V. Nutritional Problems Has your child been vaccinated for COVid19?	s your child allergic to any medica	tions?Wha	t?		
Anemia	Anemia COVid 19 Kidney Problems Psychiatric Problem Arthritis Diabetes Learning Disabilities Rheumatic Fever Asthma Ear (Hearing) Problems Liver Problems Down Syndrome Behavior Disorder Seizure Disorder Malignancies Social Problems Bleeding Problems Endocrine Disorder Intellectual Disability Speech Problems Blood Transfusion Halitosis (Bad Breath) Metabolism Problems Tonsillitis Bone(Orthopedic) Problem Heart Problems Anxiety Disorders Visual Impairment Breathing Problems Hepatitis Neurologic Problems Cerebral Palsy H.I.V. Nutritional Problems Has your child been vaccinated for COVid19?	lease place an "X" to indicate if y	our child has a history of any of the fol	lowing:		
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Asthma	Asthma	Anemia	☐ COVid 19	☐ Kidney Problems		☐ Psychiatric Problems
Behavior Disorder	Behavior Disorder	Arthritis	☐ Diabetes	☐ Learning Disabilit	ies	☐ Rheumatic Fever
Bleeding Problems	Bleeding Problems	Asthma	☐ Ear (Hearing) Problems	☐ Liver Problems		☐ Down Syndrome
Blood Transfusion	Blood Transfusion	Behavior Disorder	☐ Seizure Disorder	☐ Malignancies		☐ Social Problems
Bone(Orthopedic) Problem	Bone(Orthopedic) Problem	Bleeding Problems	☐ Endocrine Disorder	☐ Intellectual Disabi	lity	☐ Speech Problems
Breathing Problems ☐ Hepatitis ☐ Neurologic Problems	Breathing Problems ☐ Hepatitis ☐ Neurologic Problems ☐ Cerebral Palsy ☐ H.I.V. ☐ Nutritional Problems ☐ Has your child been vaccinated for COVid19?	Blood Transfusion	☐ Halitosis (Bad Breath)	☐ Metabolism Probl	ems	☐ Tonsillitis
•	Cerebral Palsy	Bone(Orthopedic) Problem	☐ Heart Problems	☐ Anxiety Disorders		☐ Visual Impairment
Cerebral Palsy H.I.V. Nutritional Problems	Has your child been vaccinated for COVid19?	Breathing Problems	☐ Hepatitis	☐ Neurologic Proble	ms	
		Cerebral Palsy	☐ H.I.V.	☐ Nutritional Proble	ms	
Has your child been vaccinated for COVid19?	re there any other pertinent facts in your child's history?	<u>Has your child been vacci</u>	nated for COVid19?			

Date:

Signature of parent or guardian: