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

Dental And Medical Health Questionnaire

Name(Child):_____**Nickname:**_____**Phone:**_____**Cell Phone**_____

Address:_____**City:**_____**Zip Code:**_____

Date of Birth:_____**Height:**_____**Weight:**_____**EMAIL:**_____

Gender:_____**Names and Ages of Brothers/Sisters**_____

Name (Parents):_____**Occupation:**_____

Business Address:_____**City:**_____**Phone:**_____

Referred by:_____**Address (or City)**_____

Reason for dental visit_____

Is this 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?**_____

Does your child participate in organized athletics?_____ **If yes, does your child wear an athletic mouthguard?**_____

Health Problems or Medications that you are taking could have an important interrelationship with the dentistry you receive. Thank you for completely filling out this form:

Physicians name:_____**Address (or City)**_____

Is your child under a physician's care at this time?_____**Why?**_____

Is your child presently taking any medication?_____**What?**_____

Has your child ever been hospitalized?_____**Why?**_____

Is your child allergic to any medications?_____**What?**_____

Please place an "X" to indicate if your child has a history of any of the following:

☐ **Allergies**	☐ **Circulatory Problem**	☐ **Intestinal Problems**	☐ **Oral Habits**
☐ **Anemia**	☐ **COVid 19**	☐ **Kidney Problems**	☐ **Psychiatric Problems**
☐ **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? _____

Are there any other pertinent facts in your child's history?_____

All of the above information is correct and I agree to be responsible for all professional fees. I understand that I am responsible for all charges or dental services and materials not paid by my dental and/or medical benefit plan. I understand that I may get a second opinion at any time before or during treatment.

Signature of parent or guardian:_____ **Date:**_____