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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:____________________________

Name 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? ____________________

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**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Behavior Disorder**
- ☐ **Bleeding Problems**
- ☐ **Blood Transfusion**
- ☐ **Bone(Orthopedic) Problem**
- ☐ **Breathing Problems**
- ☐ **Cerebral Palsy**
- ☐ **Circulatory Problem**
- ☐ **Diabetes**
- ☐ **Ear (Hearing) Problems**
- ☐ **Epilepsy**
- ☐ **Glandular Problems**
- ☐ **Halitosis (Bad Breath)**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **H.I.V.**
- ☐ **Intestinal Problems**
- ☐ **Kidney Problems**
- ☐ **Learning Disabilities**
- ☐ **Liver Problems**
- ☐ **Malignancies**
- ☐ **Mental Retardation**
- ☐ **Metabolism Problems**
- ☐ **Nervous Problems**
- ☐ **Neurologic Problems**
- ☐ **Nutritional Problems**
- ☐ **Oral Habits**
- ☐ **Psychiatric Problems**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Social Problems**
- ☐ **Speech Problems**
- ☐ **Tonsillitis**
- ☐ **Visual Impairment**

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:_________________________________

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