

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? _____

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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulatory Problem | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear (Hearing) Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Social Problems |
| <input type="checkbox"/> Behavior Disorder | <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Halitosis (Bad Breath) | <input type="checkbox"/> Metabolism Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Bone(Orthopedic) Problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neurologic Problems | |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> H.I.V. | <input type="checkbox"/> Nutritional Problems | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Oral Habits | |

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: _____