

# MEDICAL AND DENTAL HISTORY

Child's Name \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Male or Female

Primary Care Physician's name, address and phone number: \_\_\_\_\_

Please check all of the conditions that apply to your child:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Autism            | <input type="checkbox"/> Birth Defects        |
| <input type="checkbox"/> Bleeding Problems   | <input type="checkbox"/> Blood Disorders       | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Cerebral Palsey      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Down Syndrome         | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Emotional Problems   |
| <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> HIV/AIDS             |
| <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Hyperactivity/ADHD   |
| <input type="checkbox"/> Mental Retardation  | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Skin Disorders    | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Sleep Apnea/Snoring | <input type="checkbox"/> Spina Bifida          | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Speech/Hearing       |

Please list all other conditions that apply to your child: \_\_\_\_\_

Has your child ever been hospitalized? (Y/N) Please explain: \_\_\_\_\_

Please list all medications that your child takes regularly: \_\_\_\_\_

Please list all allergies and/or drug sensitivities that apply to your child: \_\_\_\_\_

What is the reason for your child's dental visit today? \_\_\_\_\_

When was your child's last visit to the dentist (if to a different office)? \_\_\_\_\_

Prior Dentist's name and phone number: \_\_\_\_\_

How do you think your child will react to this dental visit? (Circle one) Cooperative/ Uncooperative/ Not sure

How frequently does your child get his/her teeth brushed? (Circle one) 3 x day/ 2 x day/ 1 x day/ Seldom

How frequently does your child get his/her teeth flossed? (Circle one) 1 x day/1 x week/ 1 x month/ Never

Has your child ever injured his/her face/mouth/ teeth? Y/N (Circle one) Please explain: \_\_\_\_\_

Please list some of your child's interests/hobbies \_\_\_\_\_

Please state any other questions, comments or concerns \_\_\_\_\_

## AUTHORIZATION

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. I understand that any change in my child's health or medications requires that an updated medical/dental history form be completed.

\_\_\_\_\_  
Parent or Legal Guardian Date

\_\_\_\_\_  
Justin J. Bittner, D.M.D. Date

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