STARSHIP PEDIATRIC DENTISTRY

Individual Child Form: Please fill out one for for each child being treated at our office.

Patient's Name: _____ Nickname: _____

Date of birth: _____ Age: _____ School grade (if applicable): _____

Pediatrician/Medical Specialist Information:

Pediatrician name: _____ Office Name: _____

Date of last physical: _____ Please provide the name and number of any specialty doctors, if applicable: _____

_____

Please review carefully and check ☑ if your child has any history, or condition related to, any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bladder/Kidney
- ☐ Bleeding Disorders
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Sinusitis
- ☐ Diabetes
- ☐ Enlarged Tonsils
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Growth Problems
- ☐ Heart Murmur
- ☐ HIV+/AIDS
- ☐ Hyperactivity
- ☐ ADHD/ADD
- ☐ Latex Allergy
- ☐ Liver/Hepatitis
- ☐ Pregnancy (teens)
- ☐ Prosthetic Heart Valve
- ☐ Rheumatic Fever
- ☐ Sickle Cell
- ☐ Snoring
- ☐ Speech/Hearing
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Vision Disorders
- ☐ Other _____
- ☐ **None**

Health History:

Yes / No

☐ ☐ 1. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?
If yes, please list: _____

☐ ☐ 2. Is your child allergic to (please explain if yes to any)…
- Any medications? _____
- Any foods? _____
- Other? _____

☐ ☐ 3. Has your child ever been hospitalized or had surgery? Please explain: _____

☐ ☐ 4. Does your child have any mental, developmental, or physical impairment?
Please explain: _____

☐ ☐ 5. Have you ever been told you child has a heart murmur or other heart condition?
Please explain: _____

☐ ☐ 6. If you answered yes to #5, were you told your child needs antibiotic prophylaxis?

☐ ☐ 7. Has your child been diagnosed with any other illness not yet discussed in this form?
Please explain: _____

☐ ☐ 8. Are your child's immunizations up to date? If not, please explain: _____

Dental History:

Yes / No

☐ ☐ 1. Is this your child's first dental visit? If not, date of last visit? _____

☐ ☐ 2. Has your child ever had an unfavorable experience or reaction to a previous dental visit?
Please explain: _____

☐ ☐ 3. Does your child take fluoride supplements?

☐ ☐ 4. Has your child complained of recent dental pain? Please explain: _____

☐ ☐ 5. Any other dental concerns or comments? _____

Parent Signature: As this child's parent or legal guardian, I acknowledge that the information I have given is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment.

Parent or legal guardian's signature (sign at office if completing form at home):

_____ Today's date: _____

Doctor Comments:

Doctor's Signature: _____ Doctor's name: _____ Date: _____