MEDICAL INFORMATION

Child's Name: _____

Child's Pediatrician: _____ Date of Last Physical: _____

Address: _____ Phone: _____

Is your child in good health? ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever had surgery? ☐ Yes ☐ No

If yes, please explain: _____

Prior to receiving dental treatment, does your child require antibiotic pre-medication? ☐ Yes ☐ No

Is your child being treated for any condition presently? ☐ Yes ☐ No

If yes, please explain: _____

Is your child taking any over the counter or prescription medications? ☐ Yes ☐ No

If yes, please list: _____

Does your child have any allergies or reaction to any medications? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have any allergies to the following? ☐ pollen ☐ food dyes ☐ dust ☐ gluten ☐ tree nuts ☐ other

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
☐	☐	ADD/ADHD	☐	☐	Congenital heart disease	☐	☐	Mental disability
☐	☐	AIDS or HIV	☐	☐	Convulsions/seizures	☐	☐	Nutritional deficiency
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Oral ulcers
☐	☐	Asthma	☐	☐	Drug/alcohol abuse	☐	☐	Orthopedic problems
☐	☐	Autism	☐	☐	Emotional disturbance	☐	☐	PDD
☐	☐	Bladder conditions	☐	☐	Epilepsy	☐	☐	Premature birth
☐	☐	Bleeding problems/transfusions	☐	☐	Excessive gagging	☐	☐	Psychiatric disorder
☐	☐	Birth defects	☐	☐	Fainting or dizziness	☐	☐	Rheumatic fever
☐	☐	Bone or joint problems	☐	☐	Gastrointestinal problems	☐	☐	Sensory issues
☐	☐	Brain/spinal injury	☐	☐	Growth and development problems	☐	☐	Sickle cell anemia
☐	☐	Bruising problems	☐	☐	Hearing loss/deaf	☐	☐	Speech disorder
☐	☐	Cancer or malignancies	☐	☐	Heart murmur	☐	☐	Steroid therapy
☐	☐	Cerebral palsy	☐	☐	Hepatitis	☐	☐	Thyroid problems
☐	☐	Child abuse	☐	☐	Kidney disease	☐	☐	Tuberculosis
☐	☐	Chronic tonsil/adenoid infections	☐	☐	Learning disability	☐	☐	Vision problems
☐	☐	Chronic ear infections	☐	☐	Leukemia	☐	☐	Other: _____
☐	☐	Cleft lip/palate	☐	☐	Liver disease			_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or other information we should be aware of that has not been covered: _____

DENTAL INFORMATION

Is/was your child bottle fed? ☐ Yes ☐ No If so, until what age? _____

Is/was your child breast fed? ☐ Yes ☐ No If so, until what age? _____

Does your child brush daily? ☐ Yes ☐ No Does an adult assist with brushing? ☐ Yes ☐ No

Does your child floss daily? ☐ Yes ☐ No Does an adult assist with flossing? ☐ Yes ☐ No

Does your child have any of the following habits? ☐ finger sucking ☐ thumb sucking ☐ tongue thrusting ☐ nail biting ☐ pacifier ☐ teeth grinding ☐ mouth breathing ☐ lip licking ☐ sippy cup

Does your child receive any fluoride supplements? ☐ Yes ☐ No

If yes, in what form? ☐ drops ☐ vitamins/tablets ☐ toothpaste ☐ rinse/gel What is the daily dose: _____mg/day

Has your child ever had any injuries to the teeth, mouth, head or jaws? ☐ Yes ☐ No

If yes, please explain: _____

AUTHORIZATION

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Pediatric Dental Care of Wilmington of any changes in my child's medical status.

Signature of Parent or Guardian: _____ Date: _____