Medical History

SHOAL CREEK PEDIATRIC DENTISTRY, LLC

Dentistry Designed for Kids!

Patient Name:_____ **Account No.**_____ **Date of Birth:**____/____/____

☐ **New Patient** ☐ **Update for an Established Patient**

Your Child's over all health, as well as any medication your child may take is important to the dental care they receive. Please answer each question completely. Thank you!

Do any of the following apply to your child? (check any that apply):

☐ Allergy	☐ Rheumatic Fever	☐ Immune Disorders	☐ Cerebral Palsy
☐ Chronic Sinusitis	☐ Diabetes	☐ Kidney Problems	☐ Muscular Dystrophy
☐ Asthma	☐ Thyroid / Endocrine Dis.	☐ Emotional Disorder	☐ Hearing or Vision Loss
☐ Arthritis	☐ Liver Problems	☐ Autism	☐ Eating Disorders
☐ Lupus	☐ Anemia	☐ ADHD	☐ GERD
☐ Cancer (Radiation or Chemo)	☐ Hemophilia or Bleeding Dis.	☐ Mental Disability	☐ Sleep Apnea
☐ Heart Problems	☐ Tuberculosis	☐ Epilepsy or Convulsions	☐ Osteogenesis Perfecta
☐ High or Low Blood Pressure	☐ Mononucleosis	☐ Spina Bifida	☐ Ectodermal Dysplasia
☐ Infective Endocarditis	☐ HIV or Aids	☐ Hydrocephalus	☐ Cleft Palate

If your child has been diagnosed with a condition not listed above please list it here:_____

_____

Is your child taking any medications (no ☐ / yes ☐):_____

_____

Is your child allergic to any medicines or foods (no ☐ / yes ☐):_____

_____

Has your child had any surgeries or health problems now or in the past (no ☐ / yes ☐), if yes please elaborate:_____

_____

Your child's Physician:_____ / _____ / _____
(Name) (Specialty) (Phone #)

Dental History

Last Dental Visit:_____ / _____ / _____
(Name of the Dentist) (Approximate Date) (Phone #)

What is the purpose of your child's dental visit today? ☐ Comprehensive Care ☐ Mouth or Tooth Pain

☐ Other (Please Explain):_____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in strict confidence according to the guidelines set forth in the HIPPA act. It is also my responsibility to inform this office of any changes in my child medical status. I here by authorize **Dr. Thomas** and his staff to perform dental services that my child may need.

_____ _____
Signature of Parent and or Guardian Printed Name

_____ _____ _____/____/____
Signature of Dental Assistant Reviewing History Initials Date

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