all4kids pediatric dentistry
Healthy Teeth, Happy Smiles.

Child's Name: _____

DENTAL HISTORY

Former Dentist: Date of last exam:

Date of last x-rays:

Reason For Today's Visit: ☐Exam ☐Emergency ☐Consultation

How Often Does Your Child Brush? How Often Does your Child Floss?

Please check any of the following conditions that apply to your child:

☐Bad Breath
☐Bleeding Gums
☐Clicking or Popping Jaw
☐Food Collection Betw een Teeth
☐Grinding teeth
☐Loose teeth or broken Fillings
☐Sensitive to Cold
☐Sensitivity to heat
☐Sensitivity to Sw eets
☐Sores or grow ths in mouth
☐Thumb sucking
☐Nail Biting

MEDICAL HISTORY

Child's Physician: Date of Last Visit:

Address: Phone Number:

Is Child taking any of the following medications? ☐Pain Killers(including Aspirin) ☐Ritalin

☐Blood Thinners ☐Tranquilizers ☐Insulin ☐Muscle relaxers ☐Other:

Has the child ever been diagnosed with or treated for any of the following conditions?

Yes☐No☐ Heart Murmur
Yes☐No☐ Rheumatic Fever
Yes☐No☐ Artificial Heart Valves
Yes☐No☐ Congenital Heart Defect
Yes☐No☐ Scarlet Fever
Yes☐No☐ Surgeries/Operations
Yes☐No☐ Cancer/Tumors
Yes☐No☐ Chemotherapy
Yes☐No☐ Jaw Problems TMJ/TMD
Yes☐No☐ Hearing Problems
Yes☐No☐ Heart Problems
Yes☐No☐ Tonsillitis
Yes☐No☐ Respiratory Problems
Yes☐No☐ Asthma/Difficulty Breathing
Yes☐No☐ Blood Transfusion
Yes☐No☐ Leukemia
Yes☐No☐ Anemia
Yes☐No☐ Diabetes/Hypoglycemia
Yes☐No☐ Hemophilia
Yes☐No☐ Abnormal Bleeding
Yes☐No☐ Cleft Lip/ Palate
Yes☐No☐ Birth Defects
Yes☐No☐ High/Low Blood Pressure
Yes☐No☐ Hepatitis
Yes☐No☐ Artificial Bones/Joints
Yes☐No☐ Liver/Kidney Organ Problems
Yes☐No☐ HIV/AIDS/ARC
Yes☐No☐ Tuberculosis TB
Yes☐No☐ Hyper Active/ ADD
Yes☐No☐ Seizures/Epilepsy
Yes☐No☐ Cerebral Palsy

List any surgeries/operations:_____

Allergic to:
Yes☐No☐ Latex
Yes☐No☐ Penicillin/Amoxicillin
Yes☐No☐ Aspirin
Yes☐No☐ Tetracycline
Yes☐No☐ Dental Anesthetics
Yes☐No☐ Food Allergies
Other:_____

Has the child ever taken Phen fen: Yes☐No☐

Please list any other medical conditions child has or ever had:_____

I affirm that the information I gave on this form is correct to the best of my knowledge and is my responsibility to inform this office of any changes in the child's medical status. I authorize my insurance benefits be paid directly to All 4 Kids Pediatric Dentistry and I understand that I am responsible for the payment of deductibles, co-payments any balances not covered by my insurance. I also authorize All 4 Kids Pediatric Dentistry to release any information required to process the child's claims. I understand that payment is due at the time of service.

_____ _____

Dr. Signature Date Signature of parent or guardian Date