All Children's Dentistry
Pediatric Dental Specialists

Welcome To Our Office

Date:_____ Patient's Name:_____

DOB: _____ Age:_____ Sex: F / M

Phone Number:(_____)_____

Address:_____

How would you like to receive appointment reminders: text/email/call

Who should we thank for referring you?_____

Parent Information

Mother's Name:_____ DOB:_____

Address:_____

SSN:_____ Employer:_____

Cell Phone Number:_____ Home Number:_____

Email:_____

Father's Name:_____ DOB:_____

Address:_____

SSN:_____ Employer:_____

Cell Phone Number:_____ Home Number:_____

Email:_____

Insurance Information

Insurance Company:_____ Insurance Phone Number:_____

Member ID:_____ Group Number:_____ Subscriber's SSN:_____

Subscriber's Name:_____ DOB:_____

MEDICAL HISTORY

Child's Name:_____ Age_____ Date of Birth_____ ☐ Male ☐ Female

Parent/Legal Guardian's Name:_____

Address: _____

Cell Phone _____ Home Phone _____ Work Phone_____

How did you hear about our office?_____

What is the reason for your visit today?_____

Has your child ever had the following: **(CIRCLE YES OR NO)**

YES	NO	ADD/ ADHD	YES	NO	Hemophilia	YES	NO	Prolonged/ Abnormal bleeding
YES	NO	Autism	YES	NO	Hepatitis A, B, C	YES	NO	Psychiatric Care
YES	NO	Birth Defects	YES	NO	HIV positive/ AIDS	YES	NO	Seizure Disorder/Epilepsy
YES	NO	Blood Transfusion	YES	NO	Hypoglycemia	YES	NO	Shunt
YES	NO	Bruise Easily	YES	NO	Jaw difficulty: TMJ	YES	NO	Sickle Cell Anemia/Trait
YES	NO	Cerebral Palsy	YES	NO	Juvenile Rheumatoid Arthritis	YES	NO	Sleep Apnea
YES	NO	Cleft Lip or Palate	YES	NO	Kidney Problems	YES	NO	Speech or hearing problems
YES	NO	Diabetes	YES	NO	Mental Retardation	YES	NO	Spina Bifida
YES	NO	Downs Syndrome	YES	NO	Organ Transplant	YES	NO	Stomach/Liver/Kidney Problems
YES	NO	Handicaps/Disabilities				YES	NO	Tuberculosis (TB)

LUNGS

YES NO Asthma

If YES for Asthma what triggers an attack? **(circle one)**

Allergies Exercise / Exertion Stress

YES NO Medications used to treat **(circle one)**

Albuterol Nebulizer Steroids No Medications

Other medication (list here) _____

YES NO Ever been to the Emergency Room for an attack?

If YES how many times in the past 3 years? _____

CANCER

YES NO Cancer
YES NO Chemotherapy
YES NO Leukemia
YES NO Radiation Treatment

If YES which type of cancer?

_____

ALLERGIES

			Type of reaction			
YES	NO	Amoxicillin / Penicillin	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Cephalasporin / Keflex	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Codeine	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Erythromycin	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Latex	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Tetracycline	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Sulfa	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic

HEART

YES NO Congenital Heart Defect
YES NO Heart Murmur
YES NO Irregular Heart Beat
YES NO Mitral Valve Prolapse
YES NO Open Heart Surgery
YES NO Patent Ductus Arteriosus (PDA)
YES NO Prolonged Q-T Interval
YES NO Rheumatic Fever
YES NO Scarlet Fever
YES NO Ventricular Septal Defect (VSD)
YES NO Has your child ever been told to take antibiotics before dental treatment?

If YES who is cardiologist?

Name _____

Phone_____

Who is your Pediatrician?

Name_____

Phone_____

ADOLESCENT **FEMALE PATIENTS**

YES NO Is the patient PREGNANT ?

YES NO Is the patient taking BIRTH CONTROL PILLS?

List any other problems / hospitalizations your child has had:

_____

_____

List any other medications being taken:_____

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

Signature of parent or Guardian _____ Date_____