River City Dentistry, PC (Jason Allred, DMD)

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Medical & Dental History Form (Children)

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Patient's age: _____

Please take a moment to let us know about your child's medical and dental history so we may serve them more effectively and in a way that watches out for their overall health and well-being.

Would you consider your child to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in their general health? ◯ Yes ◯ No

What is the date (or approximate date) of their last medical exam?

_____

_____

Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Is your child currently under the care of a physician due to a specific condition?
- ☐ Have they been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are they currently taking any prescription or non-prescription medications?
- ☐ Any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

_____

_____

Please indicate if your child has experienced any of the following:

☐ Allergies	☐ Sulfa Allergy	☐ Penicillin Allergy	☐ Latex Allergy	☐ Hay Fever	☐ Hives
☐ Blood Disease	☐ Anemia	☐ Sickle Cell Disease	☐ Hemophilia	☐ Heart Disease	☐ Heart Murmur
☐ Heart Failure/Attack	☐ Blood Transfusion	☐ Kidney Disease	☐ Liver Disease	☐ Repiratory Problems	☐ Asthma
☐ Emphysema	☐ Tuberculosis	☐ Stomach Problems	☐ Ulcers	☐ Cancer	☐ Radiation
☐ Chemotherapy	☐ Tumors	☐ Heart Surgery	☐ Aritificial Heart Valve	☐ Artificial Joints	☐ Head Injuries
☐ Fainting	☐ Nervous Disorders	☐ Epilepsy	☐ Diabetes	☐ Thyroid Problems	☐ Jaundice
☐ Sinus Problems	☐ Chronic Cough	☐ Cold Sores/Blisters	☐ Other		

Does your child have any other health issues or allergies?

Dental Information

Previous dentist and phone number

When were last x-rays taken? _____

How long has it been since your child's last dental treatment? _____

What was done at this time? _____

What is the reason for your dental visit today?

A child's dental health is effected by many different things. The three most important to developing teeth are homecare (toothbrushing, flossing, and the use of fluoride), any habits relating to the mouth or teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions:

HABITS

Did/does your child suck his/her thumb or finger? (select all that apply)

◯ No ◯ Yes ◯ Still does ◯ Only at night

Stopped at age: _____

Does your child chew ice? ◯ Yes ◯ No

Does your child grind his/her teeth? ◯ Yes ◯ No

Does your child have any other tooth related habits? _____

HOMECARE

How frequently does your child brush their teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

Do you help with brushing?

◯ Always ◯ Sometimes ◯ Never

How frequently does your floss their teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Do you help with flossing?

◯ Always ◯ Sometimes ◯ Never

Did/does your child take Fluoride drops or tablets?

☐ No ☐ Yes ☐ Still does

If yes, at what age did he/she start taking them? _____

Does your child use a Fluoride mouthwash? (select all that apply)

☐ No ☐ Yes ☐ At home ☐ At school

Anything else you would like to add about the care of your child's teeth at home? _____

DIET

How many meals per day does your child eat? _____

How many between meal snacks (including drinks other than water) does your child have on an average day? _____

Does your child chew gum with sugar in it? ◯ Yes ◯ No

Does your child frequent snacks like raisins, fruit rollups, hard candy, breath mints, and/or suckers? ◯ Yes ◯ No

Would you like to make any comments about your child's diet? _____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

Employee initials: _____

Response Date: _____