SW PDX PEDIATRIC DENTISTRY

Dr. Melissa J. Wages, DDS

Patient Health History

PERSONAL

Child's Full Name _____ Nickname _____

Birthdate _____ Age _____ Sex: M or F Place of Birth _____

What is your child most interested in? _____

Brothers, names and ages?_____ Sisters? _____

Child's pediatrician or physician _____ Telephone #_____

How did you hear about us? _____ School name?_____

MEDICAL

Does your child have a health problem?_____ If so, what?_____

_____

Does your child have any limiting physical, mental, or emotional issues?_____ If so, what?_____

_____

What is the most serious illness your child has ever had?_____

Is your child currently under the care of a physician?____ If so, for what?_____

Does your child have or has your child ever had any of the following: (Circle all that apply)

Allergies to drugs or foods	Convulsions or epilepsy	Hemophilia or abnormal bleeding	Liver problems
Allergies to Latex	Current Immunizations	Hepatitis	Nervousness
Anemia	Developmental delay	High fevers	Rheumatic Fever
Asthma or lung problems	Diabetes	HIV+ /AIDS	Surgery
Bleeding disorders	Ear infections	Hospital stays or operations	Trauma to mouth or face
Blood transfusions	Handicaps or disabilities	Kidney problems	Tuberculosis (TB)
Cancer	Heart defect (congenital)	Learning disabilities	Cerebral Palsy
	Heart murmur		Attention Deficit Disorder

Other:_____

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics?_____ If yes, what?_____

Is your child currently taking any medications?_____ Is your child taking any supplemental fluoride?_____

Breathing problems? _____ Does your child snore? _____Breathes primarily through nose or mouth? (Circle one)

HABITS

Does your child have any of the following habits? (Circle all that apply)

Thumb or finger sucking	Pacifier Use	Tooth Grinding
Nail biting	Lip sucking or biting	Biting hard things

Did your child use a bottle?____ If yes, when did he/she stop? _____Is the bottle used at night?_____

What do you put in the bottle?_____ Is your child currently nursing? _____

FAMILY DENTAL HISTORY (Circle appropriate parent, if yes)

Has Mother or Father had many cavities? Does Mother or Father have periodontal disease?

CHILD'S DENTAL HISTORY

Has your child seen a pediatric dentist before? _____ Where?_____When? _____

Has your child had bad experiences in a dental or medical office? _____

Does your child have any dental problems presently? _____

If yes to either, please explain: _____

How often does your child brush his/her teeth per day? _____ Do you help? _____

How often does your child floss? _____ Do you floss your child's teeth? _____

How do you think your child will act toward the dentist?_____

Purpose of today's dental visit? _____

CONSENT: THE SIGNATURE OF THE PARENT/GUARDIAN BELOW AUTHORIZES THE COMPLETION OF ALL AGREED UPON DENTAL SERVICE AND THE USE OF THOSE METHODS AND TECHNIQUES APPROPRIATE THERETO. THIS CONSENT SHALL REMAIN IN FULL FORCE AND EFFECT UNTIL CANCELED BY EITHER PARTY ON BEHALF OF:

Child's Name:_____

Parent/Guardian Signature _____ Date _____ Doctor's Initials _____ Date _____

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