Great Beginnings
Pediatric Dentistry
Gentle Care for Growing Smiles

MEDICAL HISTORY UPDATE

PATIENT INFORMATION

Name :: _____

Birthdate :: _____ ☐ Female ☐ Male

Address :: _____

_____

Phone :: _____

Date of Last Physical Exam :: _____

Name/Address/Phone of Primary Physician :: _____

_____

_____

Name/Address/Phone of Medical Specialist :: _____

_____

_____

MEDICAL/DENTAL HISTORY

Do you have a primary concern regarding your child's oral health? ---------- ☐ Yes ☐ No
Describe :: _____

Is your child being treated by a physician at this time?---------- ☐ Yes ☐ No
Reason :: _____

Is your child taking any medications (prescription/over the counter), vitamins, or dietary supplements?--- ☐ Yes ☐ No
List name, dose, frequency, and date started :: _____
_____

Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year?---- ☐ Yes ☐ No
Describe :: _____

Has your child ever had a reaction to or problem with an anesthetic?---------- ☐ Yes ☐ No
Describe :: _____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?---------- ☐ Yes ☐ No
List :: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye?---------- ☐ Yes ☐ No
List :: _____

Has there been any recent significant changes/disruptions to your child's family, home, or school routine? ☐ Yes ☐ No
Describe :: _____

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Has your child had any pain or injury to the mouth/teeth/jaws since their last visit? ---------- ☐ Yes ☐ No

Describe :: _____

Has your child's diet changed significantly since their last visit?---------- ---------- ☐ Yes ☐ No

Describe :: _____

Has your child been treated by another dentis/dental professional since their last visit? ---------- ☐ Yes ☐ No

Describe :: _____

Are there any other changes in the child's medical/dental/family history that the dentist should know?--- ☐ Yes ☐ No

Describe :: _____

SIGNATURE

I understand that the information I have given is correct to the best of my knowledge. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examinations, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

Parent/Guardian Signature_____ Relationship to Patient_____

Print Name_____ Date_____