Medical Information

Patient Name: _____
Child's Pediatrician: _____
Pediatrician's Address: _____ Phone #: _____ Date of last physical: _____

Is your child in good health?	Yes	No
Are your child's immunizations up to date?	Yes	No
If your child being treated for any condition presently?	Yes	No
If so, please explain _____		
Has your child ever been hospitalized or had surgery?	Yes	No
If so, please explain _____		
Does your child have any allergies or reactions to any medications?	Yes	No
If so, please explain _____		
Does your child have any allergies to the following?	Yes	No

☐ pollen ☐ food ☐ food dyes ☐ dust ☐ other _____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CIRCLE YES (Y) OR NO (N).

Y N	Aids or HIV	Y N	Cleft Lip/Palate	Y N	Kidney Disease
Y N	Anemia	Y N	Congenital Heart Disease	Y N	Leukemia
Y N	Asthma	Y N	Convulsions/Seizures	Y N	Mental Deficiency
Y N	Autism	Y N	Diabetes	Y N	Nutritional Deficiency
Y N	Bladder Conditions	Y N	Emotional Disturbance	Y N	Oral Ulcers
Y N	Blood Transfusions	Y N	Epilepsy	Y N	Orthopedic Problems
Y N	Birth Defects	Y N	Excessive Bleeding Problems	Y N	Premature Birth
Y N	Bone or Joint Problems	Y N	Excessive Gagging	Y N	Rheumatic Fever
Y N	Brain Injury	Y N	Fainting or Dizziness	Y N	Scoliosis
Y N	Bruising Easily	Y N	Growth & Development Problems	Y N	Sickle Cell Anemia
Y N	Cancer or Malignancies	Y N	Hearing/Speech Problems	Y N	Syndrome
Y N	Cerebral Palsy	Y N	Heart Murmur	Y N	Tuberculosis
Y N	Child Abuse	Y N	Hemophilia	Y N	Other
Y N	Chronic Adenoid/Tonsil Infection	Y N	Hepatitis or Liver Disease		_____
Y N	Chronic Headaches	Y N	Hyperactivity/A.D.D./A.D.H.D.		_____
Y N	Chronic Ear Infections				_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been covered. _____

_____

Dental Information

Was your child bottle fed? If yes, until what age _____	Y	N	Does your child have any of the following mouth habits?
Was your child breast fed? If yes, until what age_____	Y	N	Finger Sucking ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Pacifier ☐
Has your child ever had injuries to his teeth, mouth,	Y	N	Lip Sucking ☐ Teeth Grinder ☐ Mouth Breather ☐ Bites Nails ☐
head or jaws? If yes, please describe_____			Does your child report any pain during chewing
_____			or while opening the mouth wide? Y N
Does your child brush daily?	Y	N	Does your child receive fluoride in any of the following forms?
Does an adult assist with the brushing?	Y	N	Vitamins ☐ Water Supply ☐ Tablets/Drops ☐
Does your child floss daily?	Y	N	Dosage:___mg/day Toothpaste ☐ Rinse/Gel ☐
Does an adult assist with flossing?	Y	N	

Consent for Treatment

I hereby authorize and direct Dr. Raffa, Dr. Athanasiou and their dental auxiliary staff to provide dental care for my child. I understand that I will be provided with answers to any questions which may arise during the course of my child's treatment.

Patient's Name: _____ Signature of Parent or Guardian: _____ Date: _____

Reviewed by: _____