

# MEDICAL HISTORY INFORMATION

PEDIATRIC DENTAL ASSOCIATES  
SPECIALISTS IN CHILDREN'S DENTISTRY  
6015- 100<sup>TH</sup> STREET SW LAKEWOOD, WASHINGTON 98499-2733

Patient's Name \_\_\_\_\_ Patient's Nickname \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Physician: Dr. \_\_\_\_\_ Date of last medical exam: \_\_\_\_\_

## 1. Is your child:

In good health: Yes  No  Taking medication(s)? Yes  No   
Under active medical care? Yes  No  Medicine(s): \_\_\_\_\_  
Explain: \_\_\_\_\_ Dose(s): \_\_\_\_\_

## 2. Has your child had any history of illness or difficulty with the following? (circle all that apply and explain below)

ADHD	ANEMIA	ASTHMA	AUTISM	BLEEDING DISORDER	CANCER
CEREBRAL PALSY	CLEFT LIP	CLEFT PALATE	DEVELOPMENTAL DELAY	DIABETES	DRUG REACTION
ENDOCRINE SYSTEM	HEART DEFECT, DISEASE, OR MURMUR	HEARING IMPAIRMENT	HEADACHES	HEPATITUS	HIV+ OR AIDS
HYDROCEPHALUS	KIDNEY	LEARNING DISABILITY	LIVER	LUNG DISEASE	SEIZURES
SPEECH DISORDER	THYROID	TUBERCULOSIS	TUMOR	VISION IMPAIRMENT	NONE

## 3. Parent Comment: (Please explain each item circled above).

\_\_\_\_\_  
\_\_\_\_\_

4. Allergies? Yes  No  If yes, describe: (i.e. drug, food, latex, etc.) \_\_\_\_\_

5. Has your child been hospitalized or required surgery? Yes  No  If Yes, describe below:

Date(s): \_\_\_\_\_

Condition(s): \_\_\_\_\_

6. Which best describes your child's personality? (circle one)

FRIENDLY SHY NERVOUS STRONG WILLED

7. Additional information: In the space below, please indicate any special concern or provide additional medical information that you think may be useful in providing dental care for your child.

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Printed Name \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

I agree to diagnostic procedures and dental treatments as found necessary and recommended by Pediatric Dental Associates for the above named patient. I authorize the release of any information relative to any insurance claim and authorize payment of my group insurance benefits, otherwise payable to me, to Pediatric Dental Associates.

I understand that I am financially responsible to the dentist for any charges not payable by the dental insurance program.

I have informed the office of Pediatric Dental Associates of all applicable dental insurance that covers my child.

Date \_\_\_\_\_ Signature of Parent of Legal Guardian \_\_\_\_\_ Printed Name \_\_\_\_\_

\_\_\_\_\_ Dental Assistant reviewing history