MEDICAL HISTORY INFORMATION

PEDIATRIC DENTAL ASSOCIATES
ORTHODONTICS AND DENTISTRY FOR CHILDREN
6015- 100TH STREET SW LAKEWOOD, WASHINGTON 98499-2733

Patient's Name_____ Patient's Nickname_____

Age_____ Sex_____ Date of Birth_____

Child's Physician:_____ Date of last medical exam: _____

Child's previous Dentist: _____ Date of last dental exam _____

Who may we thank/ How did you hear about our office_____

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	HEPATITIS	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 or Legal Guardian Printed Name

_____Dental Assistant reviewing history

-**Please Complete Other Side-**