CHURCHWELL PEDIATRIC DENTISTRY

MEDICAL AND DENTAL HISTORY

Child's Name_____ Date of Birth _____

MEDICAL HISTORY

Is your child in good health? _____
Is your child up to date with immunizations? _____
Is your child being treated for any medical condition at this time? _____
If yes, what? _____
Is your child taking any medications? _____ If yes, what? _____
Has your child been hospitalized since birth? _____ If yes, give approximate date and reason_____
_____
Does your child have a history of allergies to medications (Penicillin, Novocain, etc.)? _____ If yes, what?
_____
Does your child have a history of allergies to any other substances (latex, environmental, food, etc.)? _____
If yes, what? _____

Check any of the following that may pertain to you child

_____ Rheumatic Fever	_____ Asthma	_____ Tuberculosis
_____ Heart Condition	_____ Nervous Disorder	_____ Sickle Cell Anemia
_____ Heart Murmur	_____ Lung Problems	_____ Autism
_____ Speech Disorder	_____ Brain Injury	_____ Developmentally Delayed
_____ Hearing Disorder	_____ Epilepsy	_____ Pregnancy
_____ Vision Disorder	_____ Hepatitis	_____ Cancer
_____ Bleeding Disorder	_____ Diabetes	_____ HIV/ Aids
_____ Cerebral Palsy	_____ Down Syndrome	_____ Allergies
_____Liver Problems	_____ Mental Disorder	_____ ADD/ ADHD
_____ Kidney Problems	_____ Emotional Disorder	_____ Latex Allergy
		_____ Other _____

DENTAL HISTORY

Is this your child's first visit to a dentist? (Circle) Yes No
If not, how long since the last visit? _____
Previous Dentist: _____ Phone _____
Has your child had difficulty with previous dental/ medical visits? _____
How often does your child brush? _____
How often does your child floss? _____

Does your child…	Suck thumb/ finger/ pacifier?	Yes	No
	Grind teeth?	Yes	No
	Use a "Sippy" cup?	Yes	No
	Sleep with a bottle?	Yes	No

Have there been any injuries to teeth- falls, blows, chips, etc.? _____
Does your child have a toothache? _____
Purpose of this appointment: _____

Parent bringing patient to our office is responsible to us for payment of account.

PERMISSION:

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or legal guardian before any and/or all necessary dental service can be performed by either Dr. Caroline H. Churchwell or Dr. Molly M Churchwell. Authorization is hereby granted as such.

Signed: _____ Date: _____ Relationship: _____