

Gandy Dental

Children 12 & Under Medical and Dental History

Patient Name _____ D.O.B. _____

Parent/Guardian's Name _____ Relationship to Child _____

Emergency Contact (Name/Phone #) _____

Medical History

1. Does your child have any current health problems? Yes No
If yes, please explain: _____
2. Is your child under care of a physician? Yes No
Name of physician: _____
3. Is your child receiving any prescriptions, herbal, or OTC medications? Yes No
If yes, what and when? _____
4. Has your child had any serious illness? Yes No
If yes, what and when? _____
5. Has your child ever had surgery or is surgery contemplated? Yes No
If yes, please explain: _____
6. Does your child have a heart murmur or any other heart conditions? Yes No
7. Does your child experience severe or prolonged bleeding? Yes No
If yes, please explain: _____
8. Does your child have AIDS or has he/she tested HIV positive? Yes No
9. Has your child tested positive for hepatitis? Yes No
10. Has your child had a history of nervous disorders? Yes No
11. Does your child have frequent headaches? Yes No
If yes, please explain: _____
12. Is your child allergic/sensitive to: None Codeine Penicillin Local Anesthetic Latex
Pine Nuts Dyes Other: _____
13. Do you have, or have you ever had:

ADD/ADHD..... <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Autism..... <input type="checkbox"/> Yes <input type="checkbox"/> No Behavioral problems <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral palsy <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental delay <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures/fainting <input type="checkbox"/> Yes <input type="checkbox"/> No Eating disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Hay fever/seasonal allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing impaired <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalizations <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney infection <input type="checkbox"/> Yes <input type="checkbox"/> No Liver problems <input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No Oral herpetic lesions <input type="checkbox"/> Yes <input type="checkbox"/> No School problems <input type="checkbox"/> Yes <input type="checkbox"/> No Speech impairments <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No Take pre-medication for anything? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what for? _____
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Dental History

1. This is my child's first visit to the dentist. Yes No
2. When does your child brush his/her teeth?
Upon arising After any food Right after meals Before bedtime
3. Do you currently monitor your child's sugar intake in food, snacks, and drinks? Yes No
4. Does your child receive Fluoride in their drinking water? Yes No
5. Does your child receive supplemental Fluoride at home? Yes No
6. Have any cavities been noted in the past? Yes No
7. Does your child suck his/her thumb or fingers? Yes No
8. Were any teeth (baby or permanent) removed by extraction? Yes No
9. Has a space maintainer been recommended? Yes No
10. Has a space maintainer been placed? Yes No
11. Has your child had any problem with dental treatment in the past? Yes No
12. Has anyone in the family, including parents, had orthodontics? Yes No
13. Has your child ever received a local anesthetic? Yes No
14. Has your child ever had occlusal sealants? Yes No
If yes, when? _____
15. Does your child think there is anything wrong with his/her teeth? Yes No
16. Have there been any injuries to teeth, such as falls, blows, chips, etc.? Yes No
17. Does your child grind, clench, or brux their teeth? Yes No
Explain: _____
18. Does your child snore? Yes No
19. Is there anything else that would be valuable for your dentist to know to best care for your child? Yes No
Explain: _____

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my child's healthcare, advice, and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.
- I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's/Guardian's Signature _____ Date _____

Dentist Signature _____ Date _____