MILESTONES
PEDIATRIC DENTISTRY

Medical History

Child's name first_____middle_____last_____

Gender M F

Prefers to be called_____ Birthdate _____/_____/_____

Address: street_____city_____state_____

zip_____

Phone _____ Alternate 1 _____ Alternate 2_____

Family's primary email addres _____@_____

Future appointments may be confirmed via email. Please inform the staff if you do not wish to receive these emails.

Whom may we thank for referral? *Internet search _____ *Insurance _____ *Yellow pages_____

*Advertisement _____ *Relative/Friend_____

*Pediatrician_____ *Dentist_____ *Other_____

Parent/Guardian information:

Mother's name_____Father's name_____

Date of birth _____ Date of birth_____

SSN _____---_____---_____ SSN _____---_____---_____

Occupation_____ Occupation_____

Address (if different from above)_____

Dental insurance infomation

Primary dental insurance plan name _____ Insurance phone # _____

Subscriber's name _____ Relationship to patient _____

Subscriber's SSN or member/policy ID # _____ Member DOB _____

Group # _____ Subscriber's Employer_____

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Subscriber's name _____ Relationship to patient _____

Subscriber's SSN or member/policy ID # _____ Member DOB _____

Group # _____ Subscriber's Employer_____

Dental History

Is this your child's first visit to a dentist? Y / N If no, former dentist _____

Date of last dental visit_____ Reason for visit? _____

How many times a day is your child brushing? zero 1x 2x 3x+ Does he/she floss? Y / N

Does he/she take fluoride in any of these forms? Tablets/Drops Toothpaste Rinse/Gel Bottled H20 Other

Have any current complaint of dental pain? Y/N. If yes, please explain: _____

Does your child have a history of:

___Thumb/finger sucking ___Pacifier ___Bottle feeding ___Breastfeeding ___Sippy cup

___Speech issues ___Bleeding/Sore gums ___Mouth breathing ___Bad breath

___Grinding/clenching ___Abscess/infection ___Nsil biting ___Other _____

Medical History

Pediatrician _____ Phone_____

Address/town _____ Date of last physical _____

Please list the medications your child is currently taking:

Has your child ever been hospitalized or had surgery? Y / N If yes, please explain:

Does your child have allergies to ___Penicillin/Amoxicillin ___Sulfa ___ Latex ___ Other

(Please specify all known allergies including food and environmental allergies):

Has your child had any of the following? Please check all that apply:

_ AIDS/HIV _ Cerebal Palsy _ Jaundice (severe) _Seizures _ ADHD/ADD _ Convulsions/Epilepsy _ Kidney disease) _Sinus problems _ Anemia _Diabetes _Learning disablity _ Speech delay _ Asthma _Ear infections (chronic) _Liver disease _ Stomach/GI _ Autism/PDD/Spectrum _Genetric disorder _ Measles problems _Birth defect _Head injury _ Mononucleosis _Tuberculosis _Bleeding disorder _Hearing disability _ Mumps _Tumor _Blood transfusion _Heart mumur _Psychiatric care _Vision problems _Bone disorder _Heart problems _ Radiation therapy _Bronchitis _Hepatitis _Respiratory issues _Cancer _High blood pressure _Rheumatic fever

Other: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. If there are any changes in child's information and/or health status, I will inform the doctor as soon as reasonably possible and without fail. I understand that this information will remain confidential.

Signature of Parent/Guardian: _____

Date _____

Signature of Doctor:_____

Date _____