General Information/Health History

Full name: ____ **DOB:** ________________________ **Date:** _______________________

DENTAL HISTORY

Has your child ever been to the dentist? Yes No If yes, Dentist Name ______________________ Date ____________

Is there any history of injury to the teeth? Yes No If yes, Please describe____

Which personality best describes your child Shy Easy to warm up Active Rambunctious

Do you think your child will cooperate for dental treatment? Yes No

What is the reason for your visit today? Check Up Tooth Ache Cavities Injury Consultation/Second Opinion

HEALTH HISTORY

Is your child currently under the care of a physician? - Yes No

If yes, for what condition? ____

Is your child currently taking any **medications**? -Yes No

If yes, for what condition? ____

Please list medications ____

Does the patient currently have or have they ever been diagnosed with any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1C percentage and date:**
☐	☐	Hypertension (high blood pressure)	
☐	☐	Congenital heart disease/heart murmur. Any heart surgery or procedure. Explain all “yes” answers.	
☐	☐	Stroke	
☐	☐	Asthma	**Last attack date:**
☐	☐	Lung/Respiratory disease	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Allergies	**Please list all:**
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Obstructive sleep apnea/sleep disorders	
☐	☐	Surgeries or hospitalizations	**Please list all:**
☐	☐	Any other medical conditions not covered above	**Please list all:**

CONSENT

I am the parent or guardian of ___________________________________ (child’s name) and there are no court orders now in effect that prohibit me from signing this consent. I acknowledge that the above information is correct and grant the Doctors and Staff of Anthem Pediatric Dentistry permission to provide my child with dental and related medical/surgical treatment, utilizing proper and acceptable methods used in the specialty of pediatric dentistry, including, but not limited to radiographs (x-rays) and administration of local anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered. I understand that it is my responsibility to inform the doctor if my minor child ever has a change in health.

_______________________________ _______________________________ ______________________ ______________

Printed Name of Parent or Guardian Signature of Parent or Guardian Relationship Date