Child Dental & Medical History

Patient Name:_______________________________________
Date:____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following information as best you can.

Dental History - Please check if any apply to your child

Canker/Cold Sores
Breath Odor
Earaches
Headaches
Jaw making clicking or popping noise
Orthodontic Concerns (crooked teeth, bite)
Snore at night
Speech issues
Strong gag reflex
Frequent vomiting
Teeth Grinding
Finger/Thumb Sucking
Pacifier
Sip Cup
Nursing or bottle habit
Lip Sucking

Is this the child's first visit to a dentist? Yes or No - If not the first visit, what was the date of the last dental visit?______________
Has the child had any problems with dental treatment in the past? Yes or No
Has child ever suffered any injuries to the mouth, head, or teeth? Yes or No
Has the child had any problems with eruption or shedding of teeth? Yes or No
Has the child had any orthodontic treatment? Yes or No
What type water does your child drink? Please circle one. City Water/Well Water/Bottled Water/ Filtered Water
Does your child frequently consume carbonated beverages? Yes or No
Does your child take fluoride supplements? Yes or No
Is fluoride toothpaste used? Yes or No
How many times are child's teeth brushed per day?________ Flossed? ________ Does an adult assist? ___________
Has your child complained about dental problems? Yes or No If yes, explain____

Medical History
Physician Name:____ Name of Clinic or Facility: ____________________ _______________
Are you currently under the care of a physician? Yes or No If yes, why?____

Please check any of the following conditions that you have or have had in the past:

Abnormal Bleeding
ADD
ADHD
Anemia/Blood Disorder
Any Heart Problems
Arthritis/Rheumatism
Artificial Heart Valve Implant
Asthma/Hay Fever/Difficulty Breathing
Autism
Blood Pressure Problems - High/Low
Cancer, Type:______________
Chemotherapy/Radiation
Diabetes: Type 1 or Type 2, Controlled or Uncontrolled
Eating Disorders
Epilepsy or Seizures
Fainting or Dizzy Spells
Frequent Headaches
Hearing Impaired
Heartburn/GERD
Heart Murmur
Hepatitis - (Circle Type) A B C Other _______
Herpes/Cold Sores
HPV
Kidney/Liver Problems
Psychiatric Problems
Nervous Problems
Organ Transplant Type:_____
Osteopenia or Osteoporosis
Rheumatic Fever
Sinus Problems
Stomach Problems
Tested positive for HIV
Thyroid: Hypothyroid / Hyperthyroid
Tuberculosis

Has your child been hospitalized for serious illness or surgery not listed.
If yes, please explain:____
____

Please list any prescribed/over the counter/ vitamins you child is taking: *(if more space needed, please bring copy of list)*

Medication Name: ____Condition: ______________________
Medication Name: ____Condition: ______________________
Medication Name: ____Condition: ______________________
Medication Name: ____Condition: ______________________
Medication Name: ____Condition: ______________________
Medication Name: ____Condition: ______________________

Is your child **ALLERGIC** to any of the following:

Aspirin
Ibuprofen
Sulfa Drugs
Penicillin
Codeine
Latex, Metals, Plastics
Local Anesthetics
Food Allergy __________________
Others ______________________
____

Child Consent:
If you are unable to remain in the dental office while your child is receiving dental treatment the following circumstances will apply:

I am leaving the treatment of my child to the Doctor's judgment and experience. I understand that other treatment may be needed to be rendered by the Doctor or within the scope of routine hygiene care as followed by American Dental Association. This includes the rendering of X-rays and Fluoride. The Doctor, hygienist and staff have permission to do whatever they feel is necessary.

I case I need to be contacted, I can be reached at:____
Name *Phone*

This consent is for the duration that the below named minor patient is undergoing treatment at our office as a patient of record. The termination of this consent is only granted in the event the below minor becomes eighteen years of age or I revoke this consent to Mishicot Dental.

Terms & Conditions:
I authorize release of any information concerning my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or another dentist.

I authorize and consent to the taking of photographs of my child before, during, and after treatment. I further give permission for the use of those photographs for the purpose of research and education.

I understand that I am responsible for all costs of dental treatment.

I understand that I have a right to my child's dental records and that there may be a fee associated with receiving such records.

I hereby authorize payment of insurance benefits directly to the dentist or dental group.

Mishicot Dental does not accept any patients with insurance through the State of Wisconsin, such as Badger Care, Medical Assistance, Title 19, Forward, etc. By signing this form, I am stating that I am not covered under any state dental plan.

I attest that the above information is complete and accurate.

Signed: ____ Date: ___________________________________
Patient or Guardian Signature

Signed: ____ Date: ___________________________________
Doctor Signature