



Shoemaker Pediatric Dentistry

SHOEMAKER PEDIATRIC DENTISTRY

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HEALTH HISTORY

PATIENT NAME: _____
LAST FIRST MI

BIRTH DATE: _____

DENTAL HISTORY:

IS THIS YOUR CHILD'S FIRST DENTAL VISIT? YES NO

IF NO, WHEN WAS THE LAST VISIT? _____

PREVIOUS DENTIST (IF APPLICABLE): _____

X-RAYS TAKEN AT PREVIOUS DENTAL VISITS? YES NO

ANY INJURIES TO TEETH, FACE, OR MOUTH? YES NO

IF YES, PLEASE EXPLAIN: _____

WHAT BRINGS YOUR CHILD IN TODAY?

DO YOU HAVE ANY DENTAL CONCERNS/QUESTIONS?

HAVE PREVIOUS DENTAL EXPERIENCES BEEN POSITIVE OR
NEGATIVE? PLEASE EXPLAIN: _____

DO ANY OF THE FOLLOWING APPLY TO YOUR CHILD?

- | | |
|--|---|
| Y N | Y N |
| <input type="radio"/> <input type="radio"/> FREQUENT SNACKING | <input type="radio"/> <input type="radio"/> SIPPY CUP USE |
| <input type="radio"/> <input type="radio"/> SLEEPING WITH BOTTLE | <input type="radio"/> <input type="radio"/> THUMB-SUCKING |
| <input type="radio"/> <input type="radio"/> TEETH-GRINDING | <input type="radio"/> <input type="radio"/> PACIFIER USE |

DENTAL CARE: (AT HOME)

- | | |
|---|---|
| | Y N |
| BRUSH HIS/HER OWN TEETH | <input type="radio"/> <input type="radio"/> |
| IF YES, HOW OFTEN? | _____ (X) PER DAY |
| DO YOU BRUSH YOUR CHILD'S TEETH? | <input type="radio"/> <input type="radio"/> |
| IF YES, HOW OFTEN? | _____ (X) PER DAY |
| DIFFICULTY BRUSHING HIS/HER OWN TEETH? | <input type="radio"/> <input type="radio"/> |
| DOES YOUR CHILD FLOSS DAILY? | <input type="radio"/> <input type="radio"/> |
| DO YOU FLOSS YOUR CHILD'S TEETH? | <input type="radio"/> <input type="radio"/> |
| IS YOUR CHILD ABLE TO SPIT? | <input type="radio"/> <input type="radio"/> |
| IS YOUR CHILD USING FLUORIDE SUPPLEMENTS? | <input type="radio"/> <input type="radio"/> |
| DOES YOUR CHILD USE FLUORIDE TOOTHPASTE? | <input type="radio"/> <input type="radio"/> |

MEDICAL HISTORY:

HAS YOUR CHILD EVERY HAD ANY OF THE FOLLOWING?

- | | |
|---|--|
| Y N | Y N |
| <input type="radio"/> <input type="radio"/> ABNORMAL BLEEDING | <input type="radio"/> <input type="radio"/> HEART DISEASE/MURMUR |
| <input type="radio"/> <input type="radio"/> BLOOD DISORDERS | <input type="radio"/> <input type="radio"/> HIV+/AIDS |
| <input type="radio"/> <input type="radio"/> SICKLE CELL DISEASE | <input type="radio"/> <input type="radio"/> RHEUMATIC/SCARLET FEVER |
| <input type="radio"/> <input type="radio"/> PAST SURGERIES | <input type="radio"/> <input type="radio"/> ASTHMA |
| <input type="radio"/> <input type="radio"/> HOSPITAL STAY | <input type="radio"/> <input type="radio"/> CONGENITAL BIRTH DEFECT |
| <input type="radio"/> <input type="radio"/> CANCER | <input type="radio"/> <input type="radio"/> AUTISM |
| <input type="radio"/> <input type="radio"/> HEPATITIS | <input type="radio"/> <input type="radio"/> KIDNEY/LIVER CONDITIONS |
| <input type="radio"/> <input type="radio"/> EPILEPSY | <input type="radio"/> <input type="radio"/> HEARING IMPAIRMENT |
| <input type="radio"/> <input type="radio"/> PREGNANCY | <input type="radio"/> <input type="radio"/> ADD/ADHD |
| <input type="radio"/> <input type="radio"/> LATEX ALLERGY | <input type="radio"/> <input type="radio"/> DISABILITIES/SPECIAL NEEDS |
| <input type="radio"/> <input type="radio"/> ALLERGIES TO DRUGS | <input type="radio"/> <input type="radio"/> DIABETES |
| <input type="radio"/> <input type="radio"/> FOOD ALLERGIES | <input type="radio"/> <input type="radio"/> TUBERCULOSIS |

IF YOU MARKED ANY OF THE ABOVE AS YES, PLEASE GIVE
DETAILS: _____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS: _____

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY
TAKING: _____

PLEASE LIST ALL OF YOUR CHILD'S ALLERGIES: _____

FEMALES: STARTED MENARCHE? YES NO AGE: _____

MEDICAL PROVIDER:

PRIMARY CARE FACILITY: _____

PHYSICIAN'S NAME: _____

PHONE NUMBER: _____

WHAT IS YOUR CHILD'S CURRENT DENTAL HEALTH?

- EXCELLENT GOOD FAIR POOR

ACKNOWLEDGMENT & AUTHORITY

SINCE THE CHILD IS A MINOR, IT IS NECESSARY FOR US TO OBTAIN SIGNED PERMISSION FROM A PARENT/GUARDIAN BEFORE ANY DENTAL SERVICES CAN BE RENDERED. THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY OWN/CHILD'S MEDICAL STATUS. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE. I HAVE READ AND CONSENTED TO THE PRACTICES FINANCIAL POLICES & AGREEMENT (POSTED ONLINE & IN THE OFFICE.)

SIGNATURE OF PARENT/GUARDIAN

DATE

RELATIONSHIP TO CHILD