

Children's Dental Associates of New London County, P.C.

Patient Medical History

Please read carefully and completely answer the questions below. Thank You. **Please Print:**

Child's Name: _____ Date of Birth ____/____/____
First Middle Last

Age: _____ Sex: M F Nickname (if any): _____ Attends what School? _____

Pets: _____ Interests or Hobbies: _____ Involved in Team Sport: _____
Kind and Name

Brothers and Sisters (Names & Ages): _____

Child's Physician: Name _____ Physician's Phone Number: (____) ____ - ____

Physician's Address: _____

Does your child have regular medical exams? YES NO

Is your child currently under a physician's care for any reason? YES NO

If so, please explain _____

Has your child had any surgery, serious illness, or accident in the past? YES NO

If so, please explain _____

Is any future surgery or medical treatment planned at this time? YES NO

If so, please explain _____

Any dental problems or questions about your child's teeth? YES NO

Has your child had any history of: Heart trouble/Murmur YES NO

Rheumatic Fever YES NO

Asthma or lung problems/Cystic Fibrosis YES NO

Diabetes YES NO

Kidney or Liver disease/Hepatitis YES NO

Epilepsy or nervous system disorder YES NO

Autism/PDD/Aspergers YES NO

Fainting/Seizures YES NO

Tuberculosis YES NO

Persistent cough YES NO

Bloody Sputum YES NO

Night Sweats YES NO

Persistent Fever YES NO

Joint Replacement or Implant YES NO

Bleeding trouble/Anemia/Hemophilia YES NO

Tumor or Cancer YES NO

HIV infection or AIDS YES NO

Tobacco Use YES NO

Eating Disorder YES NO

Does your child have any mental, emotional, or physical disabilities? YES NO

If so, please explain _____

Is your child taking any medications? YES NO

If so, please explain _____

Does your child have any allergies: YES NO

medication latex metals food other

If so, please explain _____

Are your child's immunizations up to date? YES NO

Permission is hereby granted to the doctor to perform any necessary dental treatments for this child after doctor's consultation with the parent or presenting adult.

Signed _____ / _____ Date: ____/____/____ PRV's initial _____

Relationship to patient

2nd Visit Please review above information for current accuracy . Please explain any changes in your answers.

Signed _____ / _____ Date: ____/____/____ PRV's initial _____

Relationship to patient

3rd Visit Please review above information for current accuracy . Please explain any changes in your answers.

Signed _____ / _____ Date: ____/____/____ PRV's initial _____

Relationship to patient

4th Visit Please review above information for current accuracy . Please explain any changes in your answers.

Signed _____ / _____ Date: ____/____/____ PRV's initial _____

Relationship to patient

5th Visit Please review above information for current accuracy . Please explain any changes in your answers.

Signed _____ / _____ Date: ____/____/____ PRV's initial _____

Relationship to patient