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: _____
Kind and Name

Involved in Team Sport:_____

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
If so, please list _____

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_____

Has your child ever taken bisphosphonates? YES NO
If so, please explain_____

Are your child's immunizations up to date? 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
ADD/ADHD	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

Signature and review at next visit

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

_____

_____

_____

Signed_____/_____Date: ___/___/____PRV's initial_____
Relationship to patient