Patient health history

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.
SouthmoorKids.com

Patient Information

Child's name _____ Date _____

_____ Current weight (lbs.) _____

So that we may know and better understand your child, and be better prepared to render the best possible health service, it is requested that you complete the following:

Dental History

Date of last dental exam: _____ Date of last dental x-rays: _____

Has your child had dental treatment elsewhere? _____

What was his or her reaction to prior dental treatment? _____

Does your child have any dental complaints? _____ If yes, how long? _____

Is there anything you would like us to know so that we can better care for your child? _____

Medical History

Has your child ever had:

- ○ Abnormal Heart Condition
- ○ ADD/ADHD
- ○ Asthma Respiratory Disease
- ○ Autism Spectrum Disorder
- ○ Blood Disorders (ex: Anemia, Hemophilia, HIV, Hepatitis)
- ○ Cancer
- ○ Diabetes

Is your child allergic to:

- ○ Penicillin
- ○ Sulfa
- ○ Any Medication?

Has your child ever had a local anesthetic?

○ No ○ Yes

Is your child current on immunizations?

○ No ○ Yes

- ○ Genetic Disorder Syndrome
- ○ Intestinal/Stomach Problems
- ○ Kidney Problems
- ○ Liver Problems
- ○ Mental, Emotional or Development Delays
- ○ Neurologic Disorder (ex: CP, Seizures)
- ○ Any Surgical History
- ○ Frequent Headaches Relieved by: _____
- ○ TMJ (Jaw Joint Dysfunction) Relieved by: _____
- ○ Congenital Birth Defects Relieved by: _____

Does your child suck a finger, thumb or pacifier?

○ No ○ Yes Relieved by: _____

Does your child sleep with a nursing bottle?

○ No ○ Yes Relieved by: _____

Date of last physical exam: _____

Does your child have any special health care needs? _____

Is your child taking any medication? _____ If so, what? _____

Name of physician: _____ Physician phone _____

Physician address: _____

May we contact your child's physician for additional information, if necessary? _____

Briefly describe your child's personality/temperment: _____

Consent

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.

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Patient Information

Child's name _____ Date _____

Because your child is a minor it is necessary that a signed permission form be obtained from a parent or legal guardian before any treatment can be started or completed by one of our doctors. This form is for the purpose of explaining our usual office policies and procedures regarding patient care. While signing this form gives consent to us to treat your child, we encourage you to speak to any of our staff members, especially our doctors, if you have any questions regarding your child's specific needs or the treatment being provided. We always prefer to discuss your child's proposed treatment beforehand, whether it is diagnostic or restorative.

Our examination will include a hard tissue and soft tissue examination. Dental x-rays may or may not be taken, depending on your child's age, specific dental needs and their ability to cooperate. While not every patient gets dental x-rays every visit, diagnostic x-rays are necessary from time to time as your child grows. Photographs for diagnosis, treatment planning and teaching may also be taken.

Restorative and surgical treatments may be needed depending on your child's specific needs; you will be consulted in advance before any treatment. The restorative materials used may include composite resin fillings, dental sealants, silver amalgam fillings, composite resin crowns and stainless steel crowns. Restorative treatment may include nerve treatment ("pulpotomy" or "pulp capping") when necessary due to deep dental decay. Surgical treatment may include but not limited to tooth removal and minor gum or soft tissue surgery. Local anesthesia is routinely used if necessary for your child's comfort. Your child's treatment needs, if any, will be reviewed with you by the doctor at the end of the examination appointment, and before any treatment is started.

No sedative drugs are used, including nitrous oxide ("laughing gas") without prior consent by a parent. If a cooperation problem arises and we feel such sedation is indicated, you will be consulted in advance. Physical restraint is not used without a parent's consent, except as needed to protect a child from accidental self-injury during treatment. An assistant may hold your child's hands if we are concerned your child will reach up while the doctor is working.

I acknowledge that I will be responsible for arranging for payments of any bills incurred for the dental treatment on the above child.

Parent/guardian signature _____ Witness _____

Health History Updates