Print Form

Smiles for kids Pediatric Dentistry
Dental/Medical Information

Name_____ **Date of Birth**_____

Your child's health, as well as any medications which your child takes, can have an interrelationship with the dental care you child receives. Please answer each question completely.

How often does your child brush? _____
How often does your child floss? _____

Does your child:	**Yes**	**No**
Take fluoride supplements	_____	_____
Use pacifier	_____	_____
Suck thumb or finger	_____	_____
Suck or bite lip	_____	_____
Bite or chew nails	_____	_____
Grind teeth	_____	_____
Clench jaws	_____	_____
Gag easily	_____	_____
Was your child breastfed?	_____	_____
Age discontinued_____		
Was your child bottle-fed?	_____	_____
Age discontinued_____		

Has your child ever had the following (please check if any of the below apply):

____asthma
____autism
____brain injury
____bleeding disorder
____cancer
____cerebral palsy
____congenital heart defect
____diabetes
____epilepsy/seizures
____HIV/AIDS
____lung problems
____mental disorder
____anemia
____developmental delay
____speech disorder
____tuberculosis
____vision disorder
____Other_____
_____
_____
_____
___My child is healthy

Any other relevant medical/Dental condition, please explain:_____
_____
_____

Current medications taken_____
Allergies or adverse reactions to any medications (e.g. penicillin, sulfas)_____
Allergies to any substances (e.g. latex)_____
Previous hospitalizations, surgeries, or serious illnesses, and date_____
Has your child had difficulty with previous dental visits? Y N Please describe_____
_____
Date of last dental visit_____ Previous dentist_____
Child's pediatrician_____ Phone number_____

Is there anything specific you'd like to discuss with Dr. Sharma today?_____
_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary. I further acknowledge the receipt of the Dental Materials Fact Sheet and HIPAA Privacy Form.

Signature of Parent/Guardian

X_____ Date_____