Smile Place
a pediatric dentist

Patient's Name _____ Date of Birth _____ Age ____ Sex M / F

MEDICAL HISTORY

Primary Care Physician _____

Yes	No	
○	○	Is the patient in good health?
○	○	Is the patient monitored by a physician for anything other than routine care? If so, for what?
○	○	Has patient ever been hospitalized or treated in an emergency room? If so, why?
○	○	Is the patient currently taking any medication/drugs? If so, please list medications and reason.
○	○	Does patient have any allergies or drug sensitivity? If so, please list.
○	○	Has your child ever had sedation? If yes, any adverse reaction?

Check any of the following conditions which apply to the patient:

○ Currently sick/febrile	○ Heart Condition	○ Lung Disease	○ Liver Disease/Hepatitis
○ Asthma/Reactive Airway Disease		○ Rheumatic Fever	○ Cystic Fibrosis
○ Epilepsy/Seizures	○ Ears/Hearing	○ Brain injury	○ Learning Disorders
○ Endocrine Problem	○ Anemia/Sickle Cell	○ Kidney Disease	○ Blood/Bleeding Disorder
○ Tuberculosis	○ Diabetes	○ Cerebral Palsy	○ HIV/AIDS
○ Eyes/Vision	○ Headaches/Migraines	○ Sinus problems	○ Autism Spectrum Disorder
○ ADD/ ADHD	○ Autism/Asperger's	○ Fainting/Dizziness	○ Vision/Hearing Impairment
○ Speech Delay	○ Cleft Lip/Palate	○ Apnea/Sleep Study	○ Snoring/Mouth breathing
○ Cancer/Malignancy	○ Radiation/Chemo	○ Developmental Delay	○ Enlarged/Removed Tonsils/Adenoids
○ Emotional/Mental/Nervous Disorder		○ Physical Handicap	○ Gastrointestinal Problems/ Reflux
○ Shunts (VP or VA)	○ Other problems	○ Down Syndrome	

Please comment on any of the above checked items or other significant medical problems? _____

DENTAL HISTORY

Yes	No	
○	○	First Dental Visit? Previous Dentist _____ When? _____
○	○	Is your drinking water fluoridated?
○	○	Is the patient taking supplemental fluoride (i.e gel, tabs, rinses)?
○	○	Have there been any injuries to the face, mouth or teeth? If so, when? _____
○	○	Has the patient ever sucked his/her pacifier, thumb or fingers? Until what age? _____
○	○	Nighttime bottle or nursing? Until what age? _____
○	○	Does the patient have a toothache or pain today? If so, where? _____
○	○	Has any previous dental treatment occurred? If yes, what? _____
○	○	Do you expect your child to be cooperative?

How often are teeth brushed? _____ Flossed? _____ By whom? _____

Are there are any special concerns? _____

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Emergency Contact _____ Relationship _____ Phone# _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services the patient may need. I also authorize the dentist to release any information including diagnosis and the records of treatment or examination rendered to the patient during the period of such care to third-party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to Upstate Pediatric Dentistry, P.A. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to the patient. I also authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services.

_____ _____

Signature of Legal Consent Date