Pediatric Patient Health History

Lisa N. Frisicano, DDS, MS
Alan I. Newman, DDS

Patient Info

First Name | Last Name | Date of Birth | Age | Nickname

Address | Zip Code | Phone

Primary Care Physician | Phone | Medical Specialist | Phone

Medical History

Y N Does your child have any health problems (No matter how insignificant)?_____

Y N Has your child ever been in the hospital or had surgery? Reason and Date: _____

Y N Does your child have any allergies to food or medication? _____

Does your child have, or has he/she ever had the following? Check all that apply.

☐ **ADD/ADHD** ☐ **Blood Disorder** ☐ **Gastric Reflux** ☐ **HIV/ TB** ☐ **Liver Disorder** ☐ **Seizure Disorder**

☐ **Anxiety/Depression** ☐ **Cancer** ☐ **Heart Disorder** ☐ **Kidney Disorder** ☐ **Seasonal Allergies** ☐ **None of the Above**

☐ **Asthma** ☐ **Diabetes** ☐ **Other:**_____

Y N Does your child take any medications? (if YES, please list and give reason):

_____

Y N Has your child ever had an unfavorable reaction to drugs, including antibiotics? (If YES, please list)_____

Y N Does your child have an emotional/behavioral or learning disorder? (If YES, please describe): _____

_____

Dental History

Y N Does your child currently have, or have a history of any of the following? (check all that apply)

☐ **Pacifier** ☐ **Thumb** ☐ **Finger** ☐ **Lip Biting** ☐ **Nail Biting** ☐ **Grinding**

If habit ended, when? _____

Y N Has your child had a recent toothache? When? _____

Y N Has either parent had a lot of tooth decay? Whom? _____

Y N Are you satisfied with the appearance of your child's teeth?

Y N Does your child play sports? If YES, do they wear an athletic mouth guard? Y N

Y N Has your child seen an orthodontist? If YES, whom? _____

Y N Has anyone in your family had an orthodontic treatment? If YES, whom? _____

Y N Does your child have any speech issues? If YES, please explain: _____

Current Oral Health Habits

Y N Does your child receive flouride in any of the following forms? (Check all that apply)

☐ **Toothpaste** ☐ **Water** ☐ **Tablets** ☐ **Rinses** ☐ **Other**

Is your child using a **MANUAL** ◯ or **ELECTRIC** ◯ toothbrush? (Choose one)

Is it **SOFT** ◯ **MEDIUM** ◯ or **HARD** ◯? (Choose one)

How often is your child brushing? _____ times per day

Y N Do you assist your child with their oral health habits? If YES, how often? _____

Y N Does your child floss? If YES, how often?_____

Please list the snack foods your child eats and drinks:_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in health or medication, I will inform the dentist at the next appointment.

_____

Form Completed By | Signature * | Date*

_____

Dentist's Signature | Date

***If completing for digitally and emailing to us, you will be asked to sign and date when you arrive at your appointment. Please leave the above fields for signature and date BLANK.**

Pediatric Patient Info Form

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Patient Info

First Name	Last Name	Date of Birth	Male / Fema	
Address			Zip	Phone
Pediatrician Name	Phone	Specialist	Phone	

Parent/ Guardian and Family Info

Parent / Guardian Name	Last name	SSN	Birthday	Male / Fema
Address (if different from child)			City	Zip
Employer	Work Phone	Cell Phone	Home Phone	Email

Parent / Guardian Name	Last name	SSN	Birthday	Male / Fema
Address (if different from child)			City	Zip
Employer	Work Phone	Cell Phone	Home Phone	Email

Sibling('s) Names and Age(s)

Insurance Information

Primary Dental Insurance Provider		Employer	Insurance Provider Phone
Subscriber Name	Subscriber ID	Subscriber DOB	Group

Secondary Dental Insurance Provider (if applicable)		Employer	Insurance Provider Phone
Subscriber Name	Subscriber ID	Subscriber DOB	Group

Form Completed By: (Print) Signature* Date *

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