Desert Pediatric Dentistry
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Pediatric Medical History

PLEASE COMPLETE ALL SECTIONS

Child's legal name: _____ **Preferred name:** _____ **Date of birth:** ____/____/_____
Birth sex: ❑ M ❑ F Height:_____ Weight:_____ Referred By: _____ Child's Current Age:_____
Name/age and relationship of others living in the household: _____
_____
Primary physician: _____ **Address/phone:** _____ **Last visit:** _____
Medical specialists: _____ **Address/phone:** _____ **Last visit:** _____

Is your child being treated by a physician at this time? Reason _____	❑ YES	❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	❑ YES	❑ NO
List name, dose, frequency & date started: _____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?	❑ YES	❑ NO
List date & describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe _____	❑ YES	❑ NO
Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____	❑ YES	❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____	❑ YES	❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	❑ YES	❑ NO
Is your child up to date on immunizations against childhood diseases?	❑ YES	❑ NO
Is your child immunized against human papilloma virus (HPV)?	❑ YES	❑ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate)	❑ YES	❑ NO
Problems with physical growth or development	❑ YES	❑ NO
Sinusitis, chronic adenoid/tonsil infections	❑ YES	❑ NO
Sleep apnea, snoring, or mouth breathing	❑ YES	❑ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	❑ YES	❑ NO
Irregular heart beat or high blood pressure	❑ YES	❑ NO
Asthma, reactive airway disease, wheezing, or breathing problems	❑ YES	❑ NO
Cystic fibrosis	❑ YES	❑ NO
Frequent colds or coughs, bronchitis, or pneumonia	❑ YES	❑ NO
Frequent exposure to tobacco smoke	❑ YES	❑ NO
Jaundice, hepatitis, or liver problems	❑ YES	❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	❑ YES	❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	❑ YES	❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	❑ YES	❑ NO
Bladder or kidney problems or bedwetting	❑ YES	❑ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis	❑ YES	❑ NO
Rash/hives, eczema, or skin problems	❑ YES	❑ NO
Impaired vision, visual processing, hearing, or speech	❑ YES	❑ NO
Developmental disorders, learning problems/delays, or intellectual disability	❑ YES	❑ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	❑ YES	❑ NO
Autism/autism spectrum disorder or sensory integration disorder	❑ YES	❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	❑ YES	❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	❑ YES	❑ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	❑ YES	❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment	❑ YES	❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect	❑ YES	❑ NO
Diabetes, hyperglycemia, or hypoglycemia	❑ YES	❑ NO
Precocious puberty or hormonal problems	❑ YES	❑ NO
Thyroid or pituitary problems	❑ YES	❑ NO
Anemia, sickle cell disease/trait, or blood disorder	❑ YES	❑ NO
Hemophilia, bruising easily, or excessive bleeding	❑ YES	❑ NO
Transfusions or receiving blood products	❑ YES	❑ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant	❑ YES	❑ NO
Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin-resistant staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually-transmitted disease (STD), or tuberculosis (TB)	❑ YES	❑ NO

PROVIDE DETAILS HERE: _____
_____
_____

Is there any other significant medical history **pertaining to this child or the child's family** that the dentist should be told? ❑ YES ❑ NO
If YES, describe _____
_____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

your oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

the oral health of your other children? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Not applicable

Is there a family history of cavities? ❑ YES ❑ NO If yes, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	❑ YES ❑ NO	_____
Mouth sores or fever blisters	❑ YES ❑ NO	_____
Bad breath	❑ YES ❑ NO	_____
Bleeding gums	❑ YES ❑ NO	_____
Cavities/decayed teeth	❑ YES ❑ NO	_____
Toothache	❑ YES ❑ NO	_____
Injury to teeth, mouth, or jaws	❑ YES ❑ NO	_____
Clinching/grinding teeth	❑ YES ❑ NO	_____
Jaw joint problems (popping, etc.)	❑ YES ❑ NO	_____
Excessive gagging	❑ YES ❑ NO	_____
Sucking habit after one year of age	❑ YES ❑ NO	If YES, how long? _____ Which? ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other_____

How often are your child's teeth brushed? _____ times per _____ Does someone help your child brush? ❑ YES ❑ NO

How often are your child's teeth flossed? ❑ Never ❑ Occasionally ❑ Daily Does someone help your child floss? ❑ YES ❑ NO

What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ❑ City/community supply ❑ Private well ❑ Bottled water

Do you use a water filter at home? ❑ YES ❑ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel ❑ Prescription drops/tablets/vitamins

❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrician/other practitioner ❑ Other: _____

Does your child regularly eat 3 meals each day?	❑ YES	❑ NO	
Is your child on a special or restricted diet?	❑ YES	❑ NO	If YES, describe: _____
Is your child a 'picky eater'?	❑ YES	❑ NO	If YES, describe: _____
Does your child have a diet high in sugars or starches?	❑ YES	❑ NO	If YES, describe: _____
Do you have any concerns regarding your child's weight?	❑ YES	❑ NO	If YES, describe: _____

How frequently does your child have the following?

Snacks between meals	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____
Candy or other sweets	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Type _____
Chewing gum	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Usual snack _____
Soft drinks*	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____

(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities?	❑ YES	❑ NO	If YES, list: _____
Does your child wear a mouthguard during these activities?	❑ YES	❑ NO	If YES, type: _____
Has your child been examined or treated by another dentist?	❑ YES	❑ NO	

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ❑ YES ❑ NO Date of most recent dental X-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ❑ YES ❑ NO If YES, when? _____

Has your child ever had a difficult dental appointment? ❑ YES ❑ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very poorly

Is there anything else we should know before treating your child? ❑ YES ❑ NO

If yes, describe: _____

Replacement Restoration Policy

Dental benefit plans contain frequency limitations that may restrict reimbursement for replacement of fillings, stainless steel crowns, and other restorations. These limitations vary by insurance carrier and individual plan. Treatment recommendations are based on clinical findings and not on insurance coverage. Patients are responsible for fees not paid by their insurance carrier.

A. Office Courtesy Warranty

- Fillings: 12 months for material failure only.
- SSCs: 12 months for cementation failure only.

B. Insurance Replacement Policy

- Replace whenever clinically necessary.
- Submit documentation for early replacement.
- Parent responsible if carrier denies due to frequency limitations.

Signature of parent/guardian	Relationship to child	Date	Signature off staff member reviewing history