PATIENT NAME: _____ Date of Birth: ____/____/____
First M. Last

Medical Information: Primary Care Physician's name: _____ Phone #: (____)____-_____
Date of last visit: _____ Current physical health □good □fair □poor
Is the child currently under the care of a physician? □Yes □No If yes, explain reason. _____

Is the child taking any medications? □Yes □No Please list each one: _____
_____

It is important that you indicate ALL of your child's medical conditions.
Has the child ever had any of the following medical conditions? ***(Please circle Y or N for each)***

Y N	Abnormal Bleeding	Y N	Epilepsy/Seizures	Y N	Mitral Valve Prolapse
Y N	Alcohol / Drug Abuse	Y N	Fever Blisters	Y N	Psychiatric Problems
Y N	Anemia	Y N	Frequent Headaches	Y N	Rheumatic Fever
Y N	Arthritis	Y N	Glaucoma	Y N	Shingles
Y N	Artificial bones or joints	Y N	Heart Murmur	Y N	Sinus Problems
Y N	Asthma	Y N	Heart Trouble	Y N	Thyroid Condition
Y N	Blood Transfusion	Y N	Hemophilia	Y N	Tobacco Use (_____ a day)
Y N	Cancer	Y N	Hepatitis	Y N	Tuberculosis (TB)
Y N	Colitis	Y N	High Blood Pressure	Y N	Ulcers
Y N	DENTAL ANXIETY	Y N	HIV+/Aids	Y N	Venereal Disease
Y N	Diabetes	Y N	Kidney Problems		Other_____
Y N	Emphysema	Y N	Low Blood Pressure		

Please describe any conditions indicated above: _____
_____

Is the child allergic to any of the following? ***(Please circle Y or N for each.)***

Y N	Aspirin	Y N	Erythromycin	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin		

Please list any additional allergies: _____
Has the child returned from a foreign country within the last 30 days? □Yes □No
Is the child experiencing flu-like symptoms? □Yes □No

Dental History: Why have you brought your child to the dentist today? _____
Previous / Present Dentist: _____ Date of last visit: ____/____/____
Has your child ever had a serious / difficult problem associated with any previous dental work? □Yes □No
If yes, please explain: _____
Current dental health is? □Good □Fair □Poor
Does the child… Suck their thumb or finger? □Yes □No Still drink from a bottle? □Yes □No
Brush daily? □Yes □No Floss daily? □Yes □No Take fluoride supplements? □Yes □No

AUTHORIZATION: I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.
Signature: _____ **Date**: ____/____/____

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MIDLOTHIAN FAMILY DENTISTRY USE ONLY:
I verbally reviewed the medical / dental information above with the patient named herein.
Initials _____ Date____/____/____ PATIENT ID NO. _____