Farrow Pediatric Dentistry

Patient's Name _____ Preferred Name _____
DOB: _____ Age: ____ Sex: M F Grade: ____ School: _____
Siblings: _____

Dental History

Reason for visit (please circle one) Checkup Decay Habit Other_____
Previous Dentist: _____ □General □Pediatric Do you have a copy of previous x-rays? □Y □N
My Child brushes his/her teeth ____ times a day.
Do you ever help your child brush his/her teeth? □Always □Sometimes □Never
Does your child floss every day? □Y □N Is fluoride taken in any form? □tablets □drops □vitamins
Is there a history of bad dental experiences? □Y □N If yes, please explain: _____
Any injuries to the mouth/teeth? □Y □N If yes, please explain: _____
Does your child have any mouth habits?(please circle) Thumb/Finger Grinding during sleep Pacifier Sleeping with bottle Other
Is your child drinking fluoridated water? □Y □N
Does your child have difficulty breathing through the nose with his/her mouth closed? □Y □N
Has any previous dental treatment occurred? □Y □N If yes, what? _____
Any clicking, popping, or discomfort upon opening or closing mouth? □Y □N

Medical History

Child's Pediatrician: _____ City/State: _____ Phone #: _____
Date of last physical exam: _____
Has he/she ever been hospitalized or had surgery? □Y □N If so, please explain: _____
Is patient in good health? □Y □N
Any handicaps/disabilities? □Y □N If so, please list: _____

Please mark Y/N if your child has had or has any of the following:

□Y	□N	ADD/ADHD	□Y	□N	Epilepsy	□Y	□N Mumps
□Y	□N	AIDS/HIV	□Y	□N	Fainting	□Y	□N Rheumatic Fever
□Y	□N	Anemia	□Y	□N	Headaches	□Y	□N Scarlet Fever
□Y	□N	Asthma	□Y	□N	Heart Murmur	□Y	□N Seizure Disorders
□Y	□N	Autism	□Y	□N	Heart Valve Replacement	□Y	□N Sickle Cell Disease
□Y	□N	Bladder issues	□Y	□N	Hepatitis	□Y	□N Sinus Problems
□Y	□N	Bleeding issues	□Y	□N	Hemophilia	□Y	□N Speech/Hearing Problems
□Y	□N	Cancer/Tumors	□Y	□N	Kidney/Liver Disease	□Y	□N Thyroid Disease
□Y	□N	Cerebral Palsy	□Y	□N	Learning Disabilities	□Y	□N Tonsillitis
□Y	□N	Chicken Pox	□Y	□N	Measles	□Y	□N Tuberculosis
□Y	□N	Diabetes	□Y	□N	Mental Problems	□Y	□N Other: _____ _____

Girls, are you pregnant? □Y □N
Is there anything else you would like to know or that we need to know about your child?_____
_____

Medications

Please list any medications your child is currently taking and the correlation diagnosis:

_____

_____

Allergies

□None □Penicillin/Amoxicillin □Latex □Aspirin □Sulfa □Local Anesthetic □Lidocaine □Other (please list): _____

THE ABOVE DENTAL, MEDICAL AND MEDICATION HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. IT IS MY RESPONSIBILITY TO NOTIFY OF ANY CHANGE IN THE ABOVE INFORMATION AT ANY APPOINTMENT.

Signature (Parent/Guardian): _____ Date: _____