WESTFIELD PEDIATRIC DENTAL GROUP

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PATIENT HEALTH HISTORY

Patient's Full Name: _____ Age: _____ Date of Birth: ____/_____/____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: (____) _____-_____ Sex :(M) (F) Weight: _____lbs. E-Mail: _____

Mother's Cell Phone # _____ Father's Cell Phone # _____ Other # _____

Name of Physician: _____ Phone: (___) _____-_____ Name & Phone # of Pharmacy: _____

Whom may we thank for your referral? **(please specify)**

1. Sibling _____
2. Internet _____
3. Friend/Word of mouth (Name) _____
4. Dr._____
5. Newspaper/Magazine_____
6. Insurance _____
7. Yellow pages _____
8. Other _____

DENTAL AND MEDICAL HISTORY

1. What is the chief concern regarding the patients oral health? _____
2. Has the patient had any injuries to the face, mouth, or teeth? _____ Yes No
3. Were there any problems during pregnancy, delivery or during the child's first year of life? _____ Yes No
4. Is the child currently under the care of a physician? _____ Yes No
5. Has the child been in the hospital or had surgery/operation? _____ Yes No
6. Is the child currently taking any medicine? (Prescription, Vitamins, OTC, Herbal) If yes, please list. _____
7. **Does your child have ANY allergies?** If yes, please list all allergies and reaction. _____
8. Is your child currently taking fluoride supplements? If yes, please list _____
9. Please discuss any serious medical problems that the child has had: _____
10. Please describe your child's snacking habits (what types of snack and how often they snack): _____
11. Has your child had a history of: (Please circle Yes or No)

*** If yes to any of the asterisk conditions, please call prior to your appointment....premedication may be required.**

Congenital Heart Defects*	Yes No	Mitral Valve Prolapse*	Yes No	Latex Allergy	Yes No
Heart Murmur*	Yes No	Heart Murmur (innocent)	Yes No	Stomach/Intestinal Disorder	Yes No
Respiratory Problems	Yes No	Rheumatic Fever*	Yes No	Attention Deficit Disorder	Yes No
Artificial Bones/Joints	Yes No	Bleeding Disorder	Yes No	Epilepsy	Yes No
Anemia	Yes No	Sickle Cell Anemia	Yes No	Seizures	Yes No
TMJ/TMD Problems	Yes No	Liver Disease	Yes No	Developmentally Delayed	Yes No
HIV/AIDS/ARC	Yes No	Kidney Disease	Yes No	Cancer*	Yes No
Sinus Problems	Yes No	Chronic Ear Infections	Yes No	Hepatitis	Yes No
Scarlet Fever	Yes No	Tonsillitis	Yes No	Autism	Yes No
Glaucoma	Yes No	Snoring	Yes No	Speech Problems	Yes No
Asthma	Yes No	Hearing Impairment	Yes No	Diabetes (please list type)	Yes No ____
Is the patient adopted?	Yes No	Other (please list): _____			

12. Does your child have any of the following habits? Finger Sucking Pacifier Clenching/Grinding Nail Biting Other
13. Is there a history of Missing or an Abnormal Number of Teeth in the Family? If yes, list_____
14. Child's Interests, hobbies or pets _____
15. Please indicate if your child has any special needs or if there are any custodial issues our office should be aware of : _____

Please circle any of the following that may describe your child:

Outgoing	Shy	Stubborn	Anxious	Nervous
Defiant	Curious	Moody	Friendly	Cooperative

Parent/Guardian
Signature_____
Date_____

Dentist
Signature_____
Date_____