Pediatric Dentistry of Columbia

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New Patient Medical and Dental History

Welcome to our office! Careful completion of this form will assist us in providing your child with the best possible dental care.

Child's Name _____ Preferred Name _____ Today's Date___/___/____

Medical History

1) Name and phone number of child's primary care physician _____
When was your child's last check-up? _____
Is your child under the care of any specialist? ○ Yes ○ No Name and Specialty _____
2) Are all immunizations current? ○ Yes ○ No
3) Please list any allergies your child may have? (e.g. Medications, Latex, Foods) _____
4) Please list any medications that your child is currently taking? _____
5) Has your child ever been hospitalized? ○ Yes ○ No When and why? _____
6) Has your child ever had surgery or general anesthesia? ○ Yes ○ No
If so, what for and were there any complications? _____
7) Has your child ever been diagnosed as having any of the following conditions?

○ ADD / ADHD	○ Cobalaimin Deficiency	○ MTHFR Deficiency
○ Anemia	○ Congenital Birth Defects	○ Nutritional Deficiency
○ Arthritis	○ Diabetes	○ Orthopedic Problems
○ Asthma	○ Emotional Disturbance	○ Premature Birth
○ Autism	○ Eye Problems	○ Pregnancy
○ Brain Injury	○ Fainting	○ Respiratory Syncytial Virus
○ Behavioral Problems	○ Handicaps / Disabilities	○ Seizure Disorder
○ Bleeding Problems	○ Hearing Impairment	○ Sickle Cell Anemia / Trait
○ Treatment w/Bieomycin Sulfate	○ Heart Condition / Heart Murmur	○ Speech Problems
○ Breathing Problems	○ Hemophilia	○ Spina Bifida
○ Cancer / Leukemia	○ Hepatitis	○ Syndrome _____
○ Cerebral Palsy	○ Kidney / Liver Problems	○ Tetanus
○ Cleft Lip / Palate	○ Learning Disability	○ Other _____

Dental History

1) Is this your child's first visit to the dentist? ○ Yes ○ No Previous Dentist's Name? _____
If not, how long since the last visit? _____ Were X-Rays taken? ○ Yes ○ No
2) Has your child ever had any injuries to the teeth, face or mouth? ○ Yes ○ No
If yes, please explain? _____
3) Does your child have these habits? ○ Thumb / Finger Sucking ○ Lip Sucking / Biting ○ Nail Biting ○ Pacifier
4) Does your child nurse or take a bottle? ○ Yes ○ No
5) How often are the child's teeth brushed? _____ How often are the child's teeth flossed? _____
6) Is your child's water fluoridated? ○ Yes ○ No Is the child receiving fluoride supplements? ○ Yes ○ No
7) Has your child ever had a serious or difficult problem associated with previous dental work? ○ Yes ○ No
If yes, please explain _____
8) What is your reason for bringing your child to the dentist today? _____
9) How do you think your child will react today? (e.g. shy, anxious, cooperative, defiant) _____
10) Is there anything else you think we should know about your child? _____

Name _____ **Signature** _____