Dentistry for Infants, Children, Young Adults
& Patients with Special Needs

Patient Health History

Please complete the following health history for your child. This information is essential in making a thorough evaluation of your child's behavioral and dental needs. This document becomes part of our continuing evaluation of your child's growth and development. You will be asked to update this history periodically, so that we are aware of any changes in your child's medical history.

Thank you for your cooperation.

Susanne S. Wallengren, D.D.S.

Patient Registration

Patient's Name: ______________________________ Nickname: _________________________________

Birthdate: ____________ Age: _____ Sex: M/F _____

School: _______________________________________Grade: _________

Home Address: ____

City: ______________________________ State: _______ Zip: ______________

Parent's Name: ______________________________ Birthdate: _______________

Home Address: ____

City: ______________________________ State: _______ Zip: ______________

Home Phone: _____________________ Business Phone: ___________________

Cell Phone: _______________________ E-Mail:___________________________

Occupation: ______________________ Employer: _________________________

Marital Status: ___Married ___Separated ___Divorced ___Single ___Widowed

Parent's Name: ______________________________ Birthdate: _______________

Home Address:____

City: ______________________________ State: _______ Zip: ______________

Home Phone: _____________________ Business Phone: ___________________

Cell Phone: _______________________ E-Mail:___________________________

Occupation: _______________________Employer: _________________________

Marital Status: ___Married ___Separated ___Divorced ___Single ___Widowed

Names and Birthdates of Siblings: ____

Whom may we thank for referring you to our office? ____

Insurance Information

Does the patient have dental insurance? Y / N   If yes, please complete the following:

Primary Policy Holder: ___________________________ Social Security Number: ___________________

Employer: ____________________________ Group or Policy Number: _________________________

Insurance Carrier: _____________________ Claims Phone Number:___________________________

Address to Send Claim: ____

Secondary Policy Holder: _________________________ Social Security Number: ___________________

Employer: ____________________________ Group or Policy Number: _________________________

Insurance Carrier: _____________________ Claims Phone Number:___________________________

Address to Send Claim: ____

Medical History

Patient's Physician: ____ Phone: _______________________

Date of last medical visit: ____________ Purpose: ____

Is the patient under the care of a physician at this time? Y / N

If yes, for what reason? ____

Is the patient currently taking any medications? Y / N If yes, please complete the following:

	Medication:	Dosage:	Frequency:	Reason:
1)	______________________	_________	_______________	___________________
2)	______________________	_________	_______________	___________________
3)	______________________	_________	_______________	___________________
4)	______________________	_________	_______________	___________________

Has the patient ever had any unusual or allergic reactions to medications or food? Y / N

If yes, please complete the following:

Medications: ____

Foods: ____ _

Other: ____

Does the patient have a known latex allergy or sensitivity? Y / N

Has the patient ever been told they have a heart murmur or evidence of heart disease? Y / N

If yes, please describe: ____

Has the patient ever been told they need to take antibiotics prior to dental treatment, due to their heart conditions? Y / N

Were there any problems associated with the pregnancy or birth of the patient? Y / N

If yes, please describe: ____

Has the patient ever been hospitalized? Y / N

If yes, please describe: ____

Has the patient had any operations or surgical procedures? Y / N

If yes, please describe: ____

Does the patient have a history of any of the following? Please respond Y or N

___ADD/ADHD	___Diabetes Type: ___	___Obsessive-Compulsive Disorder
___Anemia/Blood Disorder	___Down Syndrome	___Organ Transplant
___Anxiety	___Feeding Problems	___Osteogenesis Imperfecta
___Asthma	___Food Allergies	___Respiratory Problems
___Autism Spectrum D/O	___HIV/Aids	___Seasonal Allergies
___Bipolar Disorder	___Heart Murmur	___Seizures
___Blind/Vision Problems	___Heart Disease/Defect	___Sickle Cell Disease
___Bleeding Disorder	___Hemophilia Type: ___	___Spina Bifida
___Cancer/Chemotherapy	___Hepatitis Type: ___	___Syndrome, Other __________
___Cerebral Palsy	___Hydrocephalus	___Tuberculosis
___Cleft Lip/Palate	___Intellectual Disability	___Tourette Syndrome
___Colitis/Crohns	___Kidney Problems	___Wheelchair
___Cystic Fibrosis	___Lactose Intolerance	___Other Problems/Illnesses
___Deaf/Hearing Problems	___Language Problems	_________________________
___Depression	___Learning Disability	_________________________
___Developmental Delay	___Liver Problems	_________________________

Dental History

What is the purpose of this appointment? ____

Has the patient ever been to a dentist prior to today's visit? Y / N If yes, please complete:

Dentist Name: _______________________________ Phone: ______________________

City/State: ____

Date of last dental visit: _____________ Purpose of last dental visit: _____________

Why have you decided to change dentists? _______________________________________

How do you expect your child to react to today's visit? ____________________________

Oral Habits

Does the patient have a history of any of the following habits? If yes, please complete:

Taking a bottle to bed at night or nap time? Y / N

Until what age? ______ What was in the bottle? _______________________________________

Pacifier? Y / N Habit Pattern: __________________ Until what age? ______________

Finger/thumb sucking? Y / N Habit Pattern: __________________ Until what age? ______________

Tongue thrust? Y / N Habit Pattern: __________________ Until what age? ______________

Mouth breathing? Y / N Habit Pattern: __________________ Until what age? ______________

Tooth grinding? Y / N Habit Pattern: __________________ Until what age? ______________

Fingernail biting? Y / N Habit Pattern: __________________ Until what age? ______________

Favorite Snacks: ____

Oral Hygiene

Does the patient brush their own teeth? Y / N When? _______________________________

Do you assist the patient in brushing? Y / N When? _______________________________

Is dental floss used in cleaning the patient's teeth? Y / N Frequency: _________________

Fluoride

Do you have well ____ or public____ water?

Is the patient currently taking fluoride supplements? Y / N If yes, please complete:

Dosage: ____

Has the patient ever taken fluoride supplements? Y / N If yes, please complete:

Dosage: ____

Has the patient ever received topical fluoride application? Y / N If yes, please complete:

Dentist applied: _____ Home rinse: _____ School rinse: ______ Brush on Rx: _____

Does the patient use toothpaste? Y / N If yes, with fluoride? Y / N

Oral Trauma

Has the patient's teeth ever been injured? Y / N

If yes, please describe: ____

Did the injury require any medical or dental treatment? Y / N

If yes, please describe: ____

Has there ever been any injury to the patient's face or jaw? Y / N

If yes, please describe: ____

Does the patient complain of clicking, popping, or crunching noises when they chew? Y / N

Has the patient's jaw ever locked open or closed? Y / N

Consent for Treatment

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever a change in the patient's health and /or medications I will inform the office. I agree to update the patient's health history as requested.

I have the legal authority to grant consent for services for the above named patient.

I give my consent for dental services to be rendered for the above named patient.

In consideration of services to be rendered, I guarantee payment of all charges incurred by the patient. I understand that I am responsible for any insurance deductibles and patient responsibilities. Please check each of the following three statements and sign below.

- I have read and understand the office Financial Policy.
- I acknowledge receipt of the Notice Of Privacy Practices for Joppa Green Pediatric Dentistry.
- If the patient is accompanied by someone other than their "legal guardian," or is in fact unaccompanied, I grant consent for all dental services deemed necessary by Joppa Green Pediatric Dentistry.

Date: __________ Signature: _____________________________________

Relation to Patient: ____