STAFF: _____

Patient Medical/Dental History

Today's Date: _____

Child's Name: _____ Preferred name: _____

Date of Birth: _____ □ Male □ Female Lives with: □ Mother □ Father □ Legal Guardian □ Foster Parents

Name of person completing this form: _____ Relationship to Patient: _____

Child's Physician:_____ Physician's Phone: (____)_____

Is this your child's first visit to the dentist? □ Yes or □ No If no who was the Previous Dentist/City? _____

Medical History: Has/Is your child;

A) Receiving any medication or drugs? _____

B) Under care for on-going condition(s)? _____

C) Ever been hospitalized/major surgery? _____

D) Allergies: Food / Drug / Latex / Seasonal Please Explain: _____

E) Immunizations current? □ Yes or □ No

Any history or difficulty with any of the following? (check all that apply)

□ Asthma □ Bleeding Disorders □ Chronic Sinus □ Hepatitis/Liver □ Hearing □ Kidney □ Rheumatic Fever □ Reflux

□ Autism Spectrum □ Cerebral Palsy □ Convulsions □ HIV/AIDS □ Developmental Delay □ Epilepsy □ Anemia

□ Physical Disabilities □ Cancer/Tumor □ Diabetes □ Fainting □ Heart (Pre-Med Y/N?) □ Other:_____

Dental History: Has/Is your child;

A) Mentioned any dental problems □ Yes or □ No? _____

B) Had any unfavorable dental experiences □ Yes or □ No? _____

C) Had any mouth / teeth / head injuries □ Yes or □ No? _____

Does your child have any of the following habits? (check all that apply)

□ Bottle at Bedtime □ Nursing at Bedtime □ Pacifier or Thumb Sucking □ Finger or Lip Sucking □ Teeth Grinding

□ Mouth Breathing □ Tongue Thrust □ Tobacco use □ Jaw Problems □ Speech Issues

Person(s) allowed to consent to treatment of patient (other than parent/guardian):

Name: _____Phone: (____)_____Relationship to Patient: _____

Name: _____Phone: (____)_____Relationship to Patient:_____

AUTHORIZATION: I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Puget Sound Pediatric Dentistry consent to do an oral exam, take appropriate x-rays, clean the teeth, give a Fluoride treatment, and provide oral hygiene instructions, as deemed appropriate. I understand I will be consulted before any another treatment is rendered. I understand that this information will be used by our dentists to help determine the appropriate and ideal dental treatment. If there is any change in my child's medical status, I will inform the office immediately.

The undersigned parent(s) or guardian(s) of the minor patient authorizes the listed person(s) to consent to treatment of the minor patient. Signing of this consent will be giving permission for these adults to discuss your child's personal medical/dental history with the staff of Puget Sound Pediatric Dentistry as needed and to make medical/dental decisions for you regarding the dental care of your child when I am not available in person. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and gives authority to the provider of care to diagnose and treat the minor in the parent/guardian's absence.

_____/_____ _____

Signature of Parent or Legal Guardian Print Name Date