Ponte Vedra Pediatric Dentistry & Orthodontics
Child's Medical & Dental History

Patient Name: ______________________________ Nickname: ________________ Date of Birth: ______________ Gender: ________

What are the child's interests and hobbies? ____

Are you permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for dental treatment of this child?
( ) Yes ( ) No

What is your main dental concern today? ____
Previous dentist's name: ________________________________ Phone: ____________________City: ______________________________
Date of last dental visit at prior dentist: _______________________________ Date of last dental x-rays: _______________________________

Primary Care Physician's Name: ______________________________ Date of Last Physical Exam: ___________ Phone: ________________

Does this child require premedication before dental treatment? ( ) Yes ( ) No If yes, please explain ______________________
Does this child have any allergies? ( ) Yes ( ) No If yes, please explain ____
Is this child allergic to any meds? ( ) Yes ( ) No If yes, which medication & reaction? _________________________________
Has this child ever been hospitalized? If yes, please explain ____
Is this child currently under the care of a physician due to a specific condition? ( ) Yes ( ) No If yes, condition:
____

Specialist's Name: ________________________ Specialty: ____________________ Phone: ______________ Last Exam **Date:** ___________

Is the child taking any medications now? ( ) Yes ( ) No
Please list any medications/vitamins/supplements the child is currently taking or prescribed for as-needed use (continue on back if needed).

List Medications:	**Treatment for:**	**Date Started:**
___________________________	___________________________	______________________
___________________________	___________________________	______________________
___________________________	___________________________	______________________

Does this child have or has this child ever had any of the following conditions? Please check if YES

( ) ADHD/Hyperactivity	( ) Chronic Cough >3 weeks	( ) Heart condition/murmur	( ) Rheumatic Fever
( ) Anemia	( ) Cleft Lip/Palate	( ) Hepatitis/Liver Disease	( ) Seizures/Epilepsy
( ) Anxiety	( ) Delayed Speech Development	( ) Herpes	( ) Sickle Cell
( ) Arthritis	( ) Depression	( ) High Blood Pressure	( ) Sinus Problems
( ) Asthma	( ) Developmentally Delay	( ) HIV/AIDS	( ) Sleep Disorder
( ) Autism	( ) Diabetes	( ) Jaundice	( ) Special Healthcare Needs
( ) Birth Defects	( ) Dizziness	( ) Joint Replacement	( ) Stomach Problems
( ) Bleeding Problems	( ) Down Syndrome	( ) Kidney Disease	( ) Stroke
( ) Blood Disease	( ) Fainting Spells	( ) Latex sensitivity	( ) Thyroid Disorder
( ) Blood Transfusions	( ) Growth Problems	( ) Migraines	( ) Tobacco Use
( ) Breathing Problems	( ) Glaucoma	( ) Pregnancy (teen)	( ) Tuberculosis
( ) Cancer	( ) Head Injury	( ) Premature/Low Birth Weight	( ) Tumors
( ) Cerebral Palsy	( ) Hearing Loss/Impairment	( ) Psychiatric/Emotional Disorder	( ) Vision Problems
( ) Radiation/Chemotherapy	( ) Other: ____________________		

If any of the previous questions are marked, please explain: ____

Printed Name: _________________________**Relationship to child:** _____________ **Signature:** ___________________________________

Doctor's Signature: ____ Today's Date: ______________________