Patient Name: _____ **Age:**_____ **Date of Birth:**_____ **Gender:** M F

Pediatrician/Primary Care Provider: _____ **Phone Number:**_____

Has your child been seen by a specialist: ☐ No ☐Yes **If yes, please indicate reason:**_____

Specialist(s) Name: _____ **Phone Number:** _____

Orthodontist: _____ **Date of last visit:**_____

Rate your child's medical health: ☐ Good ☐ Fair ☐ Poor **Immunizations up to date:** ☐ No ☐ Yes ☐ Do not immunize

Do you consider your child to be: ☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

Does your child have or have they ever had any of the following:

Y	N		Y	N		Y	N	
☐	☐	Heart Murmur / Heart Problems	☐	☐	Lung Issue / Cystic Fibrosis	☐	☐	Autism / ASD
☐	☐	Allergy to LATEX	☐	☐	Asthma	☐	☐	Physical / Mental Impairments
☐	☐	Allergy to DYES			(Last Attack_____)	☐	☐	Learning Disability / Dyslexia
☐	☐	Shunt	☐	☐	Anemia / Sickle Cell	☐	☐	Developmental Delay
☐	☐	Rheumatic Fever	☐	☐	High Blood Pressure	☐	☐	Behavioral / Personality / Social Disorder
☐	☐	Hemophilia / Bleeding Problems	☐	☐	HIV Positive / AIDS			
☐	☐	In-dwelling Catheter	☐	☐	ADD / ADHD	☐	☐	Dermatologic or Skin Conditions
			☐	☐	Frequent Headaches	☐	☐	Anesthesia / Anesthetic Issues
☐	☐	Cancer / Chemo / Radiation	☐	☐	Hearing Impairment	☐	☐	Glaucoma
☐	☐	Organ Transplant _____	☐	☐	Speech Issues	☐	☐	Sleep Apnea
☐	☐	Kidney Issue / Disease	☐	☐	Acid Reflux / GERD	☐	☐	Sleep Disorders
☐	☐	Diabetes (Last count_____)	☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Currently taking birth control
		Time taken_____)	☐	☐	Muscle Issues	☐	☐	Seasonal Allergies
☐	☐	Liver Issue / Hepatitis	☐	☐	Pregnancy	☐	☐	Strong / Excessive Gag Reflex
☐	☐	Digestive / Bladder Issues	☐	☐	Weight Issues	☐	☐	Other_____

Medicines (Prescription, Over-the-Counter, Herbal): ☐ No ☐ Yes **Please list:** _____

_____

Allergies (Medication/Food/Other Product): ☐ No ☐ Yes: **Please list:** _____

Does your child require antibiotics prior to dental treatment (heart murmur, shunt, prosthetic device, pins/screws, etc.): ☐ No ☐Yes

Has your child had: ☐ No ☐Yes **Tonsils Removed** ☐ No ☐Yes **Hospital stays/operations** ☐ No ☐Yes **Pins/Screws** **If yes to any, please describe with dates:**_____

Has your child been seen, needed to be seen, diagnosed and/or treated by a healthcare provider for any of the following:

☐ No ☐Yes **Sickness, fever, congestion, upper respiratory/sinus infection in the last 2 weeks.** ☐ No ☐Yes **Ear infection in the last 4 weeks.**

☐ No ☐Yes **Ongoing Staph/MRSA infection in the last 4 weeks.** ☐ No ☐Yes **Strep throat in the last 2 weeks.**

☐ No ☐Yes **Lice, Pink Eye, Poison Ivy/Oak last 2 weeks.** ☐ No ☐Yes **Contagious illness in last 4 weeks.**

If yes to any, by whom was your child seen and when:_____

Person Accompanying Child: Are you: ☐Parent ☐ Step-Parent ☐Grandparent ☐Other (Please specify) _____

Name (Please Print):_____**Phone:**_____

Do you have any concerns for today's visit? ☐ No ☐Yes **(If yes, please list)** _____

_____

Has your child been seen by another dentist or dental specialists since their last visit here: ☐ No ☐Yes **If yes, please describe:**

_____ **Were x-rays taken:** ☐ No ☐ Yes

Does your child have any dental problems that you are aware of, including tooth pain/injury to the mouth/teeth/jaws? ☐ No ☐ Yes

If yes, please explain: _____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status, address, phone number, email address or any other personal information. I give Pediatric Dental Specialists, P.A. permission to perform cleaning, x-rays deemed necessary for diagnosis, examination, fluoride treatment, and (sealants if applicable with prior authorization). In case of an emergency, I hereby authorize Pediatric Dental Specialists, P.A. to perform emergency and/or life-saving treatment for my child.

_____	_____	_____	_____
Patient or legal guardian if a minor)	Print Name	Relationship	Date

_____ **I give permission to Pediatric Dental Specialists, P. A. to use my child's first name and picture in their website (www.shermankidsdentists.com) or social media (i.e. Facebook page, Instagram, etc.) for future promotions and announcements.**

For Office Use Only

Provider: Harris Meredith

Medical History Reviewed By_____

Time_____ **Age**_____ **Weight**_____ **BP**_____ **Pulse**_____ **O2 Sat**_____ **ASA**_____ **TX Y N** Form 16/Rev 01.19