Pediatric DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

Provider: Dr Harris Dr. Meredith Date: _____

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

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:**_____

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

Y	N		Y	N		Y	N	
☐	☐	Heart Murmur/Heart Problems	☐	☐	Digestive / Bladder Issues	☐	☐	Physical / Mental Impairment
☐	☐	Allergy to LATEX	☐	☐	HIV Positive / AIDS	☐	☐	Learning Disability/Dyslexia
☐	☐	Allergy to DYES	☐	☐	Anemia	☐	☐	Developmental Delay
☐	☐	Shunt	☐	☐	Hearing Impairment	☐	☐	Personality / Social Disorder
☐	☐	Rheumatic Fever	☐	☐	Speech Issues	☐	☐	Dermatologic or Skin Conditions
☐	☐	Hemophilia / Bleeding Problems	☐	☐	ADD/ ADHD	☐	☐	Anesthesia Issues
☐	☐	In-dwelling Catheter	☐	☐	Frequent Headaches	☐	☐	Glaucoma
☐	☐	Diabetes (Last count_____	☐	☐	Asthma (Last Attack_____)	☐	☐	Sleep Apnea
		Time taken_____)	☐	☐	Convulsions/ Seizures / Epilepsy	☐	☐	Sleep Disorders
☐	☐	Cancer	☐	☐	Muscle Issues	☐	☐	Currently taking birth control
☐	☐	Liver Problem / Hepatitis	☐	☐	Pregnant	☐	☐	Seasonal Allergies
☐	☐	Kidney Disease	☐	☐	Autism	☐	☐	Other _____

Medicines (Prescription, Over-the-Counter, Dietary, and/or Herbal): ☐ No ☐ Yes Please list:_____

_____

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

Immunizations up to date: ☐ No ☐ Yes ☐ Do not immunize

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, or sinus infection in the last 2 weeks. ☐ No ☐Yes Ear infection within the last 2 weeks.

☐ No ☐Yes Ongoing Staph/MRSA infection within the last month. ☐ No ☐Yes Contagious disease/virus within the last 2 weeks.

☐ No ☐Yes Strep throat within the last week. 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 (please list) _____

_____

Has your child been seen by another dentist or dental specialists since their last visit here? ☐ No ☐Yes If yes, were x-rays taken:_____

The information I have given is correct to the best of my knowledge and I understand it will be held in the strictest confidence. I also 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, any x-rays deemed necessary by the doctor, exam and fluoride treatment, sealants (with prior authorization), or emergency treatment for my child.

_____ _____ _____
Signed (Patient or legal guardian if a minor) Print Name 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

Med. Hx. Reviewed by: _____

Time_____ Age_____ Weight_____ BP_____ Pulse_____ O2 Sat_____ ASA_____ **TXT Y N**