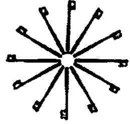

Medical and Dental History

Child's Name ______________________________ Date of Birth ________________

Please complete the following about your child:
What is the main reason you brought your child to our office?

____

Who is your child's primary physician? ____

Is your child taking any medications? Yes/No

If yes, what medications? ____

Is your child allergic to anything? Yes/No

If yes, what are they allergic to? ____

Please mark if your child has ever had any of the following:

- o Heart Disease including Murmur
- o Asthma or other Respiratory Disease
- o Jaundice, Hepatitis, Liver Disease
- o Diabetes, Thyroid, Endocrine Disease
- o Kidney Disease
- o Neurologic Disease, Cerebral Palsy
- o Seizures
- o Anemia, Hemophilia, Bleeding Disorders
- o Sickle Cell Disease or Trait
- o Cancer
- o Mental or Developmental Delay
- o Speech, Hearing or Sight Disorder
- o Immune Disorders/HIV/STD
- o Blood Products/Transfusion
- o Hospitalization/Surgery
- o Serious Illness

Please explain any marks or any other medical conditions we should know about:

____

____

Is this your child's first dental visit? Yes/No
Is your child having any dental pain? Yes/No
Has your child had a bad dental experience? Yes/No
Has your child had any dental injuries? Yes/No
Does your water have fluoride? Yes/No
Did your child ever fall asleep with a bottle? Yes/No
Does your child have any habits (pacifier, thumb, etc.)? Yes/No

________________________________ ________________________
Parent/Legal Guardian Signature Date

Tennyson Pediatric Dentistry
Patient Information Sheet
All information is confidential

PATIENT

Date:	Child's Legal Name:	Nickname:
Address:		Place of Birth:
Home Phone Number:	Social Security Number:	
Birthdate:	Age:	Gender:
School:		Grade:
Names and Ages of Siblings:		
Has your child seen the dentist before? If so, was it a good experience?		
Is there anything else we should know about your child to help make their experience better?		

PARENT

Parent(s) or Legal Guardian(s) Name(s):		Relationship to Patient:
Address:	Email Address:	
Home phone number:	Work phone number:	Occupation:
How did you hear about our office?		

Person Financially Responsible for Account

Name:		Relationship to Patient:
Address:		
Phone Number:	Birthdate:	Social Security Number:

Dental Insurance

Primary Dental Insurance		Secondary Dental Insurance	
Insurance Company:		Insurance Company:	
Address:		Address:	
Phone Number:		Phone Number:	
Name of Insured:		Name of Insured:	
Place of Employment:		Place of Employment:	
I.D. Number:	Group Number:	I.D. Number:	Group Number: