Rhonda L. Kearney, DDS, MS, PLLC **Henderson Pediatric Dentistry**
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PATIENT INFORMATION AND MEDICAL HISTORY FORM

Date: _____

Patient's Name: _____ Age: _____ Sex: _____

Date of Birth_____/_____/_____ Grade: _____ School: _____

Address: _____City: _____State:____ Zip:_____

Home Phone:_____ Patient's Social Security Number: ____-____-_____

Guardian's email: _____

PARENT INFORMATION

Parent/Legal Guardian 1: _____ Relation to patient:_____

Employer:_____ Phone:_____ Date of Birth ___/___/____

Parent/Legal Guardian 2: _____ Relation to patient:_____

Employer:_____ Phone:_____ Date of Birth ___/___/____

Who has legal custody of patient? _____ Dental Insurance: □Yes □ No

Person responsible for payment of account _____ SSN#/Member ID#: _____

Driver's License #_____

Marital Status of Parents: Married / Separated / Divorced / Other: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

Name: _____

□ From a Friend □www.hendersonpedo.com □Phone Book □Dental Office □Pediatrician/Doctor □Other

EMERGENCY CONTACT (other than parents)

Name: _____ Relationship: _____

Home Phone: _____Work Phone: _____ Mobile: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone#: _____

Mailing Address: _____ City: _____ State:____ Zip: _____

DENTAL HISTORY

What is the reason for your child's dental visit?_____

□ Yes □ No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken)_____
Name of previous dentist: _____Phone: _____

□ Yes □ No Has your child experienced any unfavorable reaction from previous dental care?
Explain _____

□ Yes □ No Does your child suck a finger, thumb, or pacifier? Which one? _____

□ Yes □ No Does your child go to bed with a bottle or sippy cup? If so, what is in it? _____

□ Yes □ No Does your child snack frequently? What are their favorite snack foods? _____

□ Yes □ No Has your child had local anesthetic? Were there any problems? _____

□ Yes □ No Has your child been sedated for dental treatment? Were there any problems? _____

□ Yes □ No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

□ Yes □ No Has your child or anyone in your immediate family ever had a cavity? If so, who and when?_____
_____

Please check if your child is having problems with any of the following:

□ Cavities	□ Orthodontics	□ Sensitive Teeth	□ Mouth Breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Toothaches	□ Jaw Sounds	□ Grinding of Teeth	

Explanations and Comments: _____
_____

---(OVER)---

FLUORIDE HISTORY

□ Yes □ No Is your home water supply fluoridated?
□ Yes □ No Does your child use a fluoride toothpaste?
□ Yes □ No Do you give your child any other forms of fluoride? What? _____
□ Yes □ No Does your child participate in a school fluoride rinse program? _____

MEDICAL HISTORY

□ Yes □ No Is your child in good health? Date of last physical exam _____
□ Yes □ No Does your child have a health problem? _____
□ Yes □ No Allergies (Please List) _____
□ Yes □ No Is your child taking any medications at this time? Please give medication, dose, and reason: _____
_____
□ Yes □ No Are your child's immunizations current?
□ Yes □ No Have you ever been told that your child needs to take *antibiotics before dental treatment*?
□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:
_____
□ Yes □ No Were there any difficulties at birth? _____

Do you consider your child to be: □ advanced in learning □ progressing normally □ slow learner

Please check if your child has been treated for any of the following:

□ Heart disease	□ Heart murmur	□ Bleeding/transfusions	□ Asthma/breathing
□ Anemia	□ Blood dyscrasias	□ Tonsil/adenoid problems	□ Tuberculosis
□ Liver/GI disease	□ Sickle cell disease/trait	□ Diabetes	□ HIV+/AIDS
□ Kidney disease	□ Rheumatic fever	□ Hepatitis	□ Mental delays
□ Speech/hearing	□ Seizures	□ Cleft lip/palate	□ Physical delays
□ Eyesight	□ Congenital birth defects	□ Personality/social	□ Cancer/tumors
□ Recurrent headaches	□ Frequent Infections	□ Adverse drug reactions	□ Cerebral palsy
□ Significant injuries	□ Endocrine/growth	□ Autism	□ Arthritis
□ ADHD	□ Spina bifida	□ Snoring	□ Abuse

Other: _____
If any boxes checked, please describe further:_____
_____
_____

I certify that I have read and understand the above information on both sides of this form to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also understand it is very important to report any changes in my child's medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain any additional information from my child's physician regarding his/her medical history needed to provide the best dental treatment possible.

I give consent for Dr. Kearney and staff to perform a dental examination, dental prophylaxis (cleaning), fluoride treatment and take x-rays on my child.

PERSON COMPLETING THIS FORM: Signature _____Date _____

Relationship to Patient: _____