Child's Name: _____ Sex: ____ Date of Birth: _____ Race: _____

Address: _____ City: _____ Zip: _____

Parent Phone #s: _____ (home) _____ (cell) _____ (email)

Teacher's Name: _____ Room #: _____

Medical doctor's name: _____ Medical doctor's phone number: _____

Is your child under the care of a medical doctor for a specific condition? ..... **Yes No**

If yes, please explain: _____

Is your child under the care of a pediatric specialist for a medical, emotional, or behavioral condition? ..... **Yes No**

If yes, please explain: _____

INSURANCE INFORMATION:

☐ Medicaid ID #: _____ ☐ Child Health Plus ID #: _____

☐ Private Dental Insurance Plan Name: _____ Policy # _____

Subscriber Name: _____ Insurance Address: _____

Subscriber Date of Birth: _____ Insurance Phone #: _____

Plan Group #: _____

HOSPITALIZATIONS AND SURGERIES:

Was your child born premature? ..... **Yes No**

If yes, how many weeks early? _____

Did your child spend time in the Neonatal Intensive Care Unit? ..... **Yes No**

If yes, how long and why? _____

Has your child had surgery? ..... **Yes No**

If yes, please explain: _____

Has your child been hospitalized for a medical condition or because of injuries? ..... **Yes No**

If yes, please explain: _____

MEDICATIONS:

Prescribed medications: _____

Over the counter medications: _____

ALLERGIES: Please circle all that apply

Local anesthetics/Novocain Penicillin Sulfa drugs Latex Foods Pine nuts Seasonal allergies Other: _____

Please explain: _____

DISEASES or CONDITIONS:

Is your child medically healthy? ..... **Yes No**

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

1. Premature birth ..... **Yes No**
2. Birth defects/inherited conditions ..... **Yes No**
3. Blood or Bleeding problems ..... **Yes No**
4. Hemophilia ..... **Yes No**
5. Sickle Cell Disease ..... **Yes No**
6. Sickle Cell Trait ..... **Yes No**
7. HIV/AIDS ..... **Yes No**
8. Hepatitis or Liver Disease ..... **Yes No**
9. Ears, eyes, nose or throat problems ..... **Yes No**
10. Sleep apnea ..... **Yes No**
11. Heart problems ..... **Yes No**
12. Congenital heart defect ..... **Yes No**
13. Lung or breathing problems ..... **Yes No**
14. Tuberculosis ..... **Yes No**
15. Asthma ..... **Yes No**
16. Digestive system problems ..... **Yes No**
17. Kidney or Bladder problems ..... **Yes No**
18. Brain or nervous system problems ..... **Yes No**
19. Cerebral Palsy ..... **Yes No**
20. Seizures/Epilepsy ..... **Yes No**
21. Developmental conditions ..... **Yes No**
22. Autism ..... **Yes No**
23. Mental or behavioral conditions ..... **Yes No**
24. ADHD ..... **Yes No**
25. Learning Disabilities ..... **Yes No**
26. Hormone problems ..... **Yes No**
27. Diabetes ..... **Yes No**
28. Bone and Muscle problems ..... **Yes No**
29. Skin problems ..... **Yes No**

Please explain any yes responses: _____

_____

Please describe any other conditions not listed above: _____

_____

DENTAL HISTORY:

Has your child seen any dentist before? ..... **Yes No**

If yes, date of last dental exam: _____

If your child has seen another dentist, please provide the name of the dentist or office: _____

Does your child have dental pain at the present time? ..... **Yes No**

Has your child injured his/her teeth, mouth or head? ..... **Yes No**

I give my permission for my child to receive a dental exam and x-rays, fillings, extractions, pulp treatments, crowns, cleanings, fluoride, and sealants. Local anesthesia may be given, and if so, care must be taken not to rub or bite lips and cheeks after procedures to avoid possible injury, swelling, or bleeding. I may discontinue my child's treatment with written notice. Ending treatment may lead possibly to pain, infection, swelling, and increased decay/disease. I consent to the release of medical information from my child's medical doctor to clarify health concerns. This medical history is to the best of my knowledge.

Signature of parent/legal guardian: _____ **date** _____

Please print parent name also: _____