LAJUAN M. HALL
D.D.S., Inc.

Check off after updating contact info □
Check off if scanned □

PEDIATRIC MEDICAL HISTORY

Child's Full Name: _____ **Nickname:** _____ **Date of Birth:** ____ / ____ / _____

Address: _____ **City:** _____ **State:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

Name/Address/phone of primary physician: _____

Name/Address/phone of medical specialists: _____

Insurance Carrier: _____

FOR INSURANCE PURPOSES, PLEASE INDICATE ONE OF THE FOLLOWING
PARENT'S MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ PARTNERED ☐ SEPARATED

Although dental personnel primarily treat the area in and around your child's mouth, the mouth is a part of the entire body. Health problems that your child may have could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Y N Is your child being treated by a physician at this time? Reason_____
Y N Is your child taking any medication (prescription or over the counter)? _____
Y N Has your child ever been hospitalized or had major surgery? _____
Y N Has your child ever had a reaction/problem with anesthetic? Describe _____
Y N Is your child up to date on immunization against childhood diseases? _____

Is your child allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Sedatives □ Sulfa Drugs □ Local Anesthetics □ Acrylic □ Dies □ Latex □ Metal
□ Other medication? List: _____

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Allergies
Y N Any Hospital Stays
Y N Artificial Valves
Y N Asthma
Y N Autism
Y N Behavioral Problems
Y N Cancer
Y N Cerebral Palsy
Y N Chronic Infection
Y N Development Delay
Y N Diabetes
Y N Fainting/Dizziness
Y N Hearing Impairment
Y N Heart Issues
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+/Aids
Y N Intestinal Problems
Y N Kidney Problems
Y N Liver Problems
Y N Rheumatic Fever
Y N Seizures/Epilepsy
Y N Sensory Concerns
Y N Sickle Cell Disease
Y N Sleep Apnea
Y N Snoring
Y N Speech Impairment
Y N Sports Injury
Y N Tuberculosis

Please explain medical problems marked YES above or any medical problems not listed: _____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ **DATE** _____ /_____ /_____

PRINTED NAME _____ **Relation to Patient** _____

SIGNATURE OF TREATING DENTIST _____ **SIGNATURE OF RDA/RDH** _____