

Smiles Dentistry for Kids

Patient Health History



Please fill in the following information for your minor child. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please understand that this information is vital to allow us to provide them the best care possible.

General Information

First Name - Patient

Middle Name

Last Name - Patient

Gender

☐ Male ☐ Female ☐ Other

Patient Date of Birth (MM/DD/YYYY)

Family Doctor

Family Doctor Phone #

Ext

Preferred Pharmacy

Pharmacy #

Parent / Guardian's Contact Information

Parent / Guardian Name

Relationship to Patient

Home #

Mobile #

Preferred Contact Method

Email Address

Patient Mailing Address

Line 1

Line 2

City

State

ZIP

Medical Information (check all that apply)

Allergies

- | | | |
|--|--|--|
| ☐ Latex | ☐ Penicillin | ☐ Amoxicillin |
| ☐ Erythromycin | ☐ Codeine | ☐ Local anesthetic |
| ☐ Aspirin | ☐ Ibuprofen | ☐ Sulfa drugs |
| ☐ Tetracycline | ☐ Metals / Nickel | ☐ Fluoride |
| ☐ Peanuts / Tree nuts | ☐ Eggs | ☐ Dairy |
| ☐ Adhesive tape | ☐ Bee stings | ☐ Seasonal / Pollen |

Other allergies (please list)

Please elaborate on any reactions you have to the indicated allergies

Conditions

Please indicate if your child has, or has had, any of the following diseases or problems.

- | | | |
|--|---|--|
| ☐ ADD / ADHD | ☐ Anemia | ☐ Anxiety |
| ☐ Asthma | ☐ Autism spectrum | ☐ Bleeding disorder |
| ☐ Blood transfusion | ☐ Cancer | ☐ Cerebral palsy |
| ☐ Congenital heart defect | ☐ Developmental delay | ☐ Diabetes |
| ☐ Down syndrome | ☐ Epilepsy / Seizures | ☐ Frequent headaches |
| ☐ Acid reflux / GERD | ☐ Growth problems | ☐ Hearing impairment |
| ☐ Heart murmur | ☐ Hemophilia | ☐ Hepatitis |
| ☐ Immune disorder | ☐ Kidney disease | ☐ Liver disease |
| ☐ Mental health condition | ☐ Prematurity at birth | ☐ Rheumatic fever |
| ☐ Sickle cell disease | ☐ Sinus problems | ☐ Sleep apnea / Snoring |
| ☐ Speech difficulties | ☐ Thyroid problems | ☐ Tonsil / Adenoid issues |
| ☐ Tuberculosis | ☐ Vision impairment | ☐ Prior hospitalization |

Additional Medical Details

Do you have any disease, condition or problem that is not listed that you think I should know about?

Is your child currently taking any medication? If yes, please list the medication and dosage.

Name and phone number of a person to contact in an emergency (other than the parent / guardian above)

Acknowledgment & Signature

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

I agree that the information provided in this form is correct to the best of my knowledge.

Print name of parent / guardian

Date

Signature of parent / guardian